AF REGULATION 160-13 AR 40-29 NAVMEDCOMINST 6120.2A CGCOMDTINST M6120.8B 20 October 1989

Medical Service

MEDICAL EXAMINATION OF APPLICANTS FOR UNITED STATES SERVICE ACADEMIES, RESERVE OFFICER TRAINING CORPS (ROTC) SCHOLARSHIP PROGRAMS, INCLUDING 2- AND 3-YEAR COLLEGE SCHOLARSHIP PROGRAMS (CSP), AND THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES (USUHS)

This regulation gives a uniform procedure for carrying out medical examinations of applicants for US service academies, Reserve Officer Training Corps (ROTC) Scholarship Programs and the Uniformed Services University of the Health Sciences (USUHS). It applies to all medical facility personnel who perform such medical examinations, including the Air National Guard and US Air Force Reserve Units.

This regulation is affected by the Privacy Act of 1974. Each form required by this regulation and which involves the Privacy Act either contains a Privacy Act Statement incorporated in the body of the document or is covered by DD Form 2005, Privacy Act Statement—Health Care Records. For a list of abbreviations shown in this publication, see attachment 1.

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Supersedes AFR 160-13, AR 40-29, NAVMEDCOMINST 6120.2, and CGCOMDTINST M6120.8A, 30 June 1986. (See signature page for summary of changes.)

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- (9) Diagnostic dental casts, if required by paragraph 9a(4), sent in a separate package, marked with the examinee's name and social security number (SSN).
- c. All items required by b above must be sent to the DODMERB. Assemble and staple all forms and dental radiographs in the order listed. Address material to: DOD Medical Examination Review Board (DODMERB), USAF Academy CO 80840-6518. DO NOT address mail to Commanding Officer, USAF Academy CO 80840-6518. This results in medical correspondence being routed to the Superintendent's office at the Air Force Academy, where it will be delayed in reaching the DODMERB.
- d. The examining facility must keep one complete copy (carbon or duplicate) of each item in b above, except b(8), then dispose of these items according to parent service record disposition standards; e.g., AFR 12-50, volume II.
 - e. Some helpful hints:
 - (1) Do:
- (a) Mail as many examination reports in one package as possible.
- (b) Send packages weighing 12 ounces or less as First-Class Mail.
- (c) Send packages weighing over 12 ounces as "Priority" mail.
- (d) Staple all papers and x-rays in the upper left corner.
- (e) Review all items for legibility and positive identification of the examinee.

(2) Do Not:

- (a) Send a letter of transmittal.
- (b) Complete or send any Privacy Act Statement (DD Form 2005, Privacy Act Statement—Health Care Records).
- (c) Send medical examination reports or remedial medical information via Certified or Registered mail.
- 6. Hospitalization of an Applicant. When hospitalization is required as part of the medical examination, the applicant may be admitted to a DOD MTF under the authority of appropriate service regulations; e.g., AFR 168-6, AR 40-3, NAVMEDCOMINST 6320.3, Uniform Military Training and Service Act (62 Stat 604.50 U.S.C., App 451).
- 7. Civilian Consultation and Additional Evalua-

- are essential to evaluate an examinee properly, the examining facility should do them whenever possible.
- a. If these services are not available, the facility may purchase these services from civilian sources, at government expense, providing funds are available. If funds are not available, or these service cannot be offered because of scheduling. distance, or the like, the examinee must be given the opportunity to travel at his or her own expense to a government facility that can provide these services. In that case, tell the examinee to call the other government facility for an appointment in advance. The examinee may also get these services, at his or her own expense, from a civilian source, and have results sent directly to the address in paragraph 5c. Applicant should be provided SF 513, Medical Record—Consultation Sheet, which provides pertinent history and specifically delineates the specialty information needed and authorized lab tests required. Invasive or potentially dangerous procedures are not authorized. Communicate with DODMERB in questionable cases.
- b. Results of the medical examination should be sent without waiting for supplementary evaluations or their results. Any instructions given to the examinee will be explained on DD Form 2351. Results of additional tests or evaluations should be sent separately, when they become available.
- 8. Direct Communication. The Director, DOD-MERB, is authorized to communicate directly with the commanders of each designated examining facility about medical examinations, procedures, techniques, deficiencies, and general supervision of medical examination processing. The Director, DODMERB, may send a copy of any correspondence with the examining facilities to the office of primary responsibility of the appropriate Surgeon General office.

9. Scope of Examination:

a. Dental Examination:

(1) General Information. The dental officer thoroughly examines the mouth, teeth, and supporting structures of the examinee and records his or her findings in blue-black or black ink on the DD Form 2480 (attachment 4). While the examining dental officer must inform the candidate of existing deficiencies, pathology, or abnormalities, the examiner is not authorized to

examiner should not point out the specific treatment that might be needed to meet the standards. If such instructions are necessary, the DODMERB must give these instructions to the examinee after evaluating all results of the dental examination. Generally, all dental expenses will be borne by the examinee. Dental radiographs and study casts are authorized to be obtained from the Departments of the Army, Navy and Air Force dental facilities at no expense to the examinee.

- (2) Dental Radiographs. All examinees receive the Type 2 Dental Examination. This includes both mirror and explorer examination under adequate illumination. Bite-wing radiographs on bite-wing film and a panoramic radiograph are required. When an examinee is wearing a fixed, active orthodontic appliance, excluding retainers on both arches, only a panoramic radiograph is required. Bite-wing x-rays are not needed in these cases. A full mouth x-ray survey should not be performed in place of a panoramic x-ray.
- (a) If the examination facility does not have a panoramic x-ray, offer the examinee the opportunity to go to another government facility, traveling at his or her own expense. In such cases, advise the examinee to call for an appointment. As an alternative, the examinee may obtain the panoramic x-ray (and not a full-mouth survey) from a civilian dentist at his or her own expense.
- (b) The examining dental officer may obtain additional radiographs (for example, periapical or occlusal views) if it is necessary to demonstrate pathology or other abnormalities.
- (c) Identify all radiographs with the examinee's full name and SSN. Process thoroughly, and wash and dry radiographs before sending them to the DODMERB. All x-rays must be of diagnostic quality.
- (3) Charting Dental Defects. All dental defects of the examinee are shown on DD Form 2480. Indicate on the chart (DD Form 2480, item 3) all teeth that are restorable or nonrestorable, missing teeth, teeth replaced, spaces closed, location of cavities, and any defects or abnormalities of the teeth and surrounding structures. Do not chart existing restorations unless they are defective.
- (4) Diagnostic Dental Casts. In cases of questionable occlusion, disfiguring spaces between anterior teeth, malformation of the jaw, or malrelation of the jaw, dental casts must be made of maxillary and mandibular dental

- arches. Leave any existing prosthetic appliances in place when you make impressions. Draw pencil lines across facial surfaces of both casts to show the habitual occlusal relationship. Identify each cast clearly with the examinee's name and SSN, and send both casts to the DOD-MERB. Indicate on DD Form 2480, item 10l, that you are sending casts.
- (5) Malocclusion. Any questionable occlusion or definite malocclusion related to an insufficient incisal or masticatory function, the malformation or malrelation of jaws or opposing teeth, or a facial deformity must be noted on the DD Form 2480, item 10. Any additional remarks about the type, degree, or severity of the malocclusion should be added in item 16 (attachment 4)
- (6) Orthodontics. If the examinee wears a fixed, active orthodontic appliance, or is undergoing orthodontic treatment that includes an active removable appliance, or is wearing retainer appliances, or has a past history of orthodontic treatment, please note that fact on the DD Form 2480, item 11.
- (7) Periodontal Conditions. If significant periodontal disease is present (not simply gingivitis), the location, nature, and severity of the problem must be described on the DD Form 2480, item 13.
- (8) Dental Prostheses. The dental examination must include an opinion about the service-ability of all dental prostheses. A serviceable prosthesis must adequately restore masticatory function and appearance, and permit clear speech. Oral tissues supporting the prosthesis must be healthy. Any comments must be recorded on the DD Form 2480, item 12.
- (9) Cleft Palate or Cleft Lip. If the examinee has a history of cleft palate or cleft lip, whether repaired or not, your comments must be recorded on the DD Form 2480, item 9d and e, to include existing fistulae or other defects.

b. Medical Examinations:

- (1) DD Form 2492, DODMERB Report of Medical History:
- (a) The examinee's complete medical history must be recorded on the DD Form 2492.
- (b) The examinee completes the first two lines, all of Sections I and II (items 1 through 94), and the Remarks (if necessary) of the DD Form 2492 in his or her own handwriting, using blue-black or black ink or indelible pencil.
- (c) The examinee's identification is selfexplanatory, but you may help the examinee fill out these items in the standard format.

- (d) The examinee completes items 1 through 94 and Remarks (the examinee should mark "Not Applicable" or "N/A" in item 9, if appropriate). If item 21 "wear contact lenses or ocular eye retainers," is marked "yes," explain type of lenses or retainers and length of time removed before examination (see attachment 3). As the examinee may give vague or imprecise information in the "Remarks" section, all answers must be carefully reviewed, and the examinee asked to clarify answers, whenever necessary (note that answers in items 1 through 10 do not need remarks). The examiner must elaborate on medical history items that are not adequately explained by examinee.
- (e) Some general guides for completing examiner's summary and elaboration of pertinent data:
- 1. Do not use the term "usual child-hood illnesses." You may group childhood illnesses together, listing each one.
 - 2. Record the date or age of incidents.
- 3. Do not use "NS" or "nonsymptomatic" in the history. You may use "NCNS," "no comp, no seq," or "no complications, no sequelae" after items of history.
- 4. Elaborate on all items of history answered "Yes" that are not adequately explained by examinee. Number your amplifying responses to correspond to the affirmative responses on DD Form 2492.
- (2) DD Form 2351. Attachment 2 gives an item-by-item explanation of DD Form 2351, with model entries. Complete all items, as specified.

10. Supply of Forms:

- a. DD Forms 2351, 2480, and 2492 are part of the scheduling package DODMERB sends to lists of applicants provided by the academies, ROTC programs and the USUHS.
- b. Local reproduction of blank DD Forms 2351, 2480, and 2492 is authorized by the Army, Navy, Coast Guard, and Air Force through the applicable forms manager and reproduction facility. Print DD Forms 2480 and 2492 head-to-foot. Print DD Form 2351 face only.
- c. The DD Forms listed below are provided to the applicant by DODMERB when remedial medical tests are required; however, a small stock of these forms will be maintained by each medical facility in the event applicants arrive at the medical facility without the appropriate forms to record remedial test results. Local

- reproduction is authorized based on the specific requirement of the particular agency.
- (1) DD Form 2369, DOD Medical Examination Review Board (DODMERB) Cycloplegic Refraction (attachment 5).
- (2) DD Form 2370, DOD Medical Examination Review Board (DODMERB) Three-Day Blood Pressure and Pulse Check (attachment 6).
- (3) DD Form 2371, DOD Medical Examination Review Board (DODMERB) Update of Applicant's Medical Examination (attachment 7).
- (4) DD Form 2372, DOD Medical Examination Review Board (DODMERB) Statement of Present Health (attachment 8).
- (5) DD Form 2374, DOD Medical Examination Review Board (DODMERB) Heart Murmur Evaluation (attachment 9).
- (6) DD Form 2375, DOD Medical Examination Review Board (DODMERB) Pulmonary Function Studies (attachment 10).
- (7) DD Form 2377, DOD Medical Examination Review Board (DODMERB) Red/Green Color Vision Test (attachment 11).
- (8) DD Form 2378, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Headaches (attachment 12).
- (9) DD Form 2379, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Head Injury (attachment 13).
- (10) DD Form 2380, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Sleepwalking (attachment 14).
- (11) DD Form 2381, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Motion Sickness (attachment 15).
- (12) DD Form 2382, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Hay Fever, Sinusitis, Asthma and/or Allergies (attachment 16).
- (13) DD Form 2383, DOD Medical Examination Review Board (DODMERB) Statement of Use Regarding Medication (attachment 17).
- (14) DD Form 2489, DOD Medical Examination Review Board (DODMERB) Farnsworth Lantern Color Vision Test (attachment 18). When locally reproduced, print head-to-foot.
- d. DD Forms 2368, DOD Medical Examination Review Board (DODMERB) Service Academy ROTC Medical Qualification Determination; 2373, DOD Medical Examination Review Board (DODMERB) Notification of Failure to Appear for Service Academy ROTC Medical

Examination; and 2503, DOD Medical Examination Review Board (DODMERB) Applicant Overseas Appointment, are stocked and used only by DODMERB.

e. Attachment 19 provides guidelines for conducting certain medical tests; e.g., Reading Aloud Test (RAT), sitting height, Red Lens Test, etc.

BY ORDER OF THE SECRETARIES OF THE AIR FORCE, THE ARMY, THE NAVY, AND THE DEPARTMENT OF TRANSPORTATION

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WILLIAM O. NATIONS, Colonel, USAF Director of Information Management and Administration

OFFICIAL

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MICHAEL HUDGINS
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Chief, Office of Health and Safety
US Coast Guard

SUMMARY OF CHANGES

This revision clarifies procedures MTFs will follow when applicants arrive who are not scheduled by DODMERB (para 2); permits the use of DD Form 2492 as an exception to SF 93, Report of Medical History, which will be used to report a medical history to DODMERB (paras 5a and 9b); advises examining facilities of the proper format for addressing medical correspondence to the DODMERB (para 5c); includes remedial medical information as being prohibited from being mailed Certified or Registered Mail (para 5e(2)(c); clarifies procedures examining physicians will follow when applicant must be hospitalized as part of the medical examination (para 6); adds additional information about applicants requiring specialty consultations and laboratory procedures before their examination (para 7); redesignates DODMERB Form 6, Report of Dental Examination to DD Form 2480 (para 9a); adds a list of abbreviations (atch 1); adds an explanation and model entry for blood alcohol testing and urine drug screen (atch 2, item 29); rescinds DD Form 2376, Supplemental Statement of Medical History.

Distribution:

Air Force: F

Army: Active Army, ARNG, USAR: To be distributed in accordance with the requirements on DA Form 12-09-E, block number 3434, intended for command level B.

Navy: Ships and Stations Having Medical Department Personnel.

(Stocked: CO, NAVPUBFORMCEN, 5801 Tabor Ave., Phila., PA 19120-5099)

Coast Guard: To be distributed by Commandant (G-TIS) pursuant to COMDTNOTE 5600

LIST OF ABBREVIATIONS

ANSI-American National Standards Institute

ASA-American Standards Association

BAT-Blood Alcohol Test

cm-Centimeters

CSP-College Scholarship Program

CT-Cover Test

°-Degree

DOD-Department of Defense

DODMERB-Department of Defense, Medical

Examination Review Board

DPA-V—Depth Perception Apparatus—Ver-

hoeff

ECG-Electrocardiographic

EKG-Electrocardiogram

FALANT—Farnsworth Lantern

GU-Genitourinary System

HIV—Human Immune Virus

Hz-Hertz

ISO-International Standards Organization

mm-Millimeters

MTF-Medical Treatment Facility

NCNS-No Complications, No Sequelae

NE-Not Examined

NPC-Near Point of Convergence

NS-Nonsymptomatic

OTC-Over the Counter

PA-Physician Assistant

PAS-Privacy Act Statement

PC—Point of Convergence

PCNP—Primary Care Nurse Practitioner

POC-Professional Officer Course

RAT-Reading Aloud Test

RBC-Red Blood Cell

ROTC—Reserve Officer Training Corps

SSN-Social Security Number

UDS-Urine Drug Screen

USUHS-Uniformed Services University of the

Health Sciences

VTA-ND-Vision Test Apparatus-Near and

Distant

VTS-CV-Vision Test Set-Color Vision

WBC-White Blood Cell

WHNS-Well Healed, No Sequelae

DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION

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ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351

ITEM-BY-ITEM EXPLANATION FOR FILLIN	NG OUT DD FORM 2551
Explanation	Model Entry
Item 1—Date of Examination. Record dates in military style.	14 January 1985 21 Mar 85
Item 2—Last Name, First Name, Middle Name. Record the entire middle name.	Jones, Harry William, Jr. Martinez, Catherine, Lucinda
Item 3—Social Security Number.	111-22-3333 001-01-1001
Item 4a—Date of Birth. Record date in military style.	15 Feb 68 29 Apr 67
Item 4b—Age.	17 18
Item 5—Sex. Do not abbreviate.	Male Female
Item 6—Race (Ethnic Group). Do not abbreviate. Do not confuse with religion.	Caucasian, Black, Oriental, Indian (American), Puerto Rican, Mexican-American
Item 7—Home Address. Enter the address and nine-digit ZIP code where the examinee receives mail.	1234 Main St. Colorado Springs CO 80840-6518
Item 8—Military Status. Check the block designating the applicant's current status.	
Item 9—Examiner Address. Complete name and address of agency doing examination	USAF School of Aerospace Medicine Brooks AFB TX 78235-5000
Item 10—Height. Record standing height in inches, without shoes, to the nearest quarter of an inch. Also measure every applicant's sitting height to the nearest quarter of an inch, and record it.	Standing 61 1/4 Sitting 36 3/4
Item 11—Blood Pressure. Record the sitting blood pressure.	120/84
Item 12—Electrocardiogram (EKG). Give every examinee a 12-lead EKG. The examinee does not have to be fasting. Check normal or abnormal, and submit actual tracings.	
Item 13—Audiometer. Give an audiometer test, include frequencies 500, 1000, 2000, 3000, 4000, and 6000 Hertz (Hz). Indicate the type of standard (American National Standards Institute (ANSI) American Standards Association (ASA), 1951, or International Standards Organization (ISO), 1964.	
Item 14—Reading Aloud Test (RAT). Give the RAT (attachment 19) and mark it as "satisfactory" or "unsatisfactory." If RAT is unsatisfactory, summarize the defects that caused failure in item 57.	

Item 15—Pulse. Record the resting pulse in beats per minute. 72

Item 16—Weight. Measure weight in pounds, to the nearest whole pound, with the examinee wearing no more than

underwear.

Items 17 through 26. Before conducting vision test, find out if the examinee is wearing contact lenses. Soft contact lenses must be removed a minimum of 3 days before the examination. All other types of contact lenses (hard, semisoft, retainers, color-correcting, etc.) must be removed 21 days before the examination. If contact lenses have not been out the required period of time, note the fact in item 57 and continue with the examination. Have the examinee remove them for those tests where lenses would obviously cause erroneous results, such as items 17 and 19 (uncorrected vision). If the examinee usually wears corrective lenses (spectacles or contacts), have the examinee wear them during depth perception and color vision testing; however, make sure that lenses are not "color corrective."

Item 17—Distant Vision. Record distant visual acuity with a constant numerator of 20 (20 feet), and a denominator that depends on the individual's vision. If acuity is worse than 20/20, right eye or left eye, then record the correctable visual acuity. If the examinee is not able to read all of the letters on the 20/20 line, then record the number of missed letters; e.g., 20/20-1; 20/30-2; 20/20-3, etc., or record the next higher line; e.g., 20/20-3 = 20/25. Measure visual acuity with Vision Test Apparatus-Near and Distant (VTA-ND), or in the eye lane. When using the VTA-ND and the examinee does not successfully complete the top line of the 20/400 line, then record 20/400+ or refer examinee to the optometrist to determine the proper visual acuity.

Item 18—Refraction. OTHER THAN US AIR FORCE ACADEMY. Complete this item on every examination where distant or near visual acuity is worse than 20/20, right eye or left eye. Enter the prescription that corrects acuity to 20/20, and after the word "Refraction" mark how you derived that prescription; "manifest," "cycloplegic," or "lens" if the prescription is read from spectacles.

US AIR FORCE ACADEMY. Every applicant for the US Air Force Academy whose uncorrected distant visual acuity is 20/20 or better in both the right and left eyes must have a cycloplegic refraction. Enter the prescription that corrects acuity to no better than 20/20 and after the word "Refraction" check "CYCLO."

Item 19—Near Vision. Record results in terms of reduced Snellen. Whenever the uncorrected vision is worse than normal (20/20), show the corrected vision for each eye, and lens value after the word "by."

Item 20—Heterophoria. In routine testing for heterophoria, check only "Far" on the VTA-ND, or "20" in the eye lane. Do not enter the symbol for diopters; the unit of measurement is understood. Enter the amount of exophoria or esophoria and right or left hyperphoria.

Model Entry

20/50 corrected to 20/20 20/20-3 corrected to 20/20 20/400+

Refraction (manifest By SPH - 1.50 CYL + .50 AXIS 090

20/40 corrected to 20/20 by same. 20/40 corrected to 20/20 by +0.50

Es° Ex° R.H. L.H. 8 0 1 0

Item 21—Cover Test. Test muscle balance deviation (phorias or tropias) by use of the objective Cover Test (CT). If you find esotropia or exotropia on the CT (cross or alternate cover and cover-uncover) check "fail" and record the amount in the bottom of the box. If the examinee is orthophoric, check "pass."

Item 22—Color Vision. Test examinees with the standard 15-plate Vision Test Set, Color Vision (VTS-CV). Check the test(s) used and enter both the number passed and the number failed. If the Farnsworth Lantern (FALANT) is available, use it for those who fail the plate test. Also, use it if you suspect the examinee has memorized the plates. Enter FALANT results to the right of the word "FALANT." Be sure to specify the name of other tests and the numerical result. If the examinee fails the FALANT or 15-plate Vision Test Set, check for the ability to distinguish and identify, without confusion, those colors of objects, substances, materials, or lights that are vivid red and vivid green; record results in item 57.

Item 23—Depth Perception. Test the examinee with correction, if any. For VTA-ND if the examinee passes, enter "passes" and give the highest level passed (D, E, or F) in parentheses. For Verhoeff (DPA-V), enter "passes" or "fails" and the number correct over number presented. For Titmus/Stereo Fly, circle the actual test used and enter the numerical result.

Item 24—PC (Near Point of Convergence). Measure the near point of convergence (NPC) in millimeters (mm).

Item 25—Accommodation. Have the examinee take this test with corrective lenses if worn.

Item 26—Red Lens Test. Note the point on the screen where diplopia or suppression develops. Mark "pass" if the examinee has no diplopia or suppression within 20 inches of the primary position in the center of screen, with the examinee seated 30 inches from the screen. Describe any abnormalities accurately in item 57.

Item 27—Urinalysis. Check the appropriate boxes for protein and sugar. Indicate results of microscopic examination; multi-reagent strips may be used if negative. If the multireagent strip is not negative, an actual microscopic examination must be performed and the results annotated.

Item 28a and b—Blood Type and RH Factor. Record results in these blocks.

Item 28c and d—Hematocrit and Hemoglobin. A hematocrit or hemoglobin level is required.

Item 29—Other Tests. For other medical tests as indicated; e.g., HIV (all exams), dental results (POC only), blood alcohol testing (BAT) and urine drug screen (UDS).

Model Entry

- a. VTA-ND passes (F)
- b. DPA-V passes (8/8)
- c. Titmus/Stereo Fly 70

35mm

Right 10.0, Left 9.5

Diplopia in left lateral gaze, 10 inches from primary position.

2 RBC 3 WBC

Type A
Rh factor—Pos

Hematocrit 44 Hemoglobin 16.5

HIV—Negative Dental Class 2 BAT—Negative UDS—Collected

Items 30 through 56—Clinical Evaluation. Make a check in the proper column. When there are clinical findings to record or comment on, check the proper column (normal or abnormal) and enter pertinent information in the space provided to the right, beginning with the item number. (See instructions on DD Form 2351).

Item 30—Head, Neck, Face, and Scalp. Record all swollen glands, deformities, or imperfections of the head and face. If enlarged lymph nodes of the neck are detected, describe them in detail and give a clinical opinion of the etiology.

Item 31—Nose. Record all abnormal findings. If septum is deviated, estimate the degree of obstruction and tell whether airflow is adequate.

Item 32—Sinuses. Record objective findings only.

Item 33—Mouth and Throat. Note whether tonsils have been removed. Record any unusual findings.

Item 34—Ears—General (Including External Canals). If operative scars are noted over the mastoid area, include a notation of simple or radical mastoidectomy in item 57.

Item 35—Drums (Perforation). Record the location and size of any perforation. If there is scarring of the tympanic membrane, record the percent of the membrane involved, and evaluate the mobility of the membrane.

Item 36—Valsalva. Indicate whether or not both eardrums move on Valsalva Maneuver (mark normal only if both drums move).

Item 37—Eyes—General. When there is ptosis of lids, make a statement about the cause and whether it interferes with vision. When you detect a pterygium, note the following:

- (a) Encroachment on the cornea.
- (b) Progression.
- (c) Vascularity. Check particularly for radial keratotomy or evidence of orthokeratology or other procedures employed to improve visual acuity.

Item 38—Pupils (Equality and Reaction).

Item 39—Ocular Motility (Associated Parallel Movements, Nystagmus).

Item 40—Ophthalmoscopic. If you detect opacities of the lens, make a statement about size, type, progression, and interference with vision.

Model Entry

- a. 2cm vertical scar right forehead, well healed, no sequelae (WHNS).
- b. 2 discrete, freely movable, firm, 2cm nodes in right anterior cervical chain, probably benign. Has upper respiratory infection.
- a. Moderate obstruction on right, due to septal deviation, airflow adequate, asymptomatic.
- b. Mouth breathing noted.
- c. Large nasal polyps present in both chambers.

Marked tenderness over left maxillary sinus. Poor transillumination.

Tonsils enucleated.

Bilateral severe swelling, injection, and tenderness of ear canals.

Small perforation, right upper quadrant of left tympanum.

No motion on valsalva, right ear.

- a. Ptosis, bilateral, congenital. Does not interfere with vision.
- b. Pterygium, left eye. Does not encroach on cornea, nonprogressive avascular.

Redistribution of pigment, macula, right eye, possibly due to solar burn. No evidence of active organic disease.

Item 41-Lungs and Chest (Include Breasts). Record all abnormal findings. Note whether there are any abnormalities of the rib cage, muscles, chest excursion, palpation, percussion, and auscultation.

Item 42—Heart (Thrust, Size, Rhythm, Sounds). Describe any abnormal heart findings completely. Whenever you hear a cardiac murmur, describe the time in the cardiac cycle, and the intensity, location, transmission, and effect of respiration or change in position; and state whether you think that the murmur is organic or functional. When describing murmurs by grade, indicate basis of grade (IV or VI). Note any additional sounds (clicks, etc.) and their time in the cardiac cycle, synchrony, and intensity; and whether you think they are of cardiac origin or adventitious.

Item 43—Vascular System (Varicosities, etc.). Describe any abnormalities adequately. When varicose veins are present, give their location, severity, and evidence of venous insufficiency. Check for the presence or absence of carotid, radial, femoral, popliteal, and pedal pulses. Specifically, record any absent pulses or presence of a bruit over any artery.

Item 44-Abdomen and Viscera (Include Hernia). Note any abdominal scars and describe the length in centimeters, their location and direction. If you find a dilated inguinal ring, state whether a hernia is present or absent.

Item 45—Endocrine System. Specifically record asymmetry, enlargement, or the presence of nodules in the thyroid gland.

Item 46—Spine, Other Musculoskeletal (Including Pelvis, Sacroiliac, and Lumbosacral Joints). If you detect scoliosis or other musculoskeletal defects, either by examination or as an incidental chest x-ray finding, describe any defects as accurately as possible.

Item 47—Upper Extremities. Record any deformity or limitation of motion. If the applicant has a history of previous injuries or fracture of an upper extremity (for example, a history of a broken arm with no significant finding at time of examination), indicate that there is no deformity and function is normal. Make a positive statement, even though you check the "Normal" column.

Item 48—Lower Extremities. Report as in item 47.

Item 49—Feet. Note any abnormality. When you detect flat Flat feet, moderate, stable, asymptomatic. feet, make a statement about the stability and the presence or absence of symptoms. Do not express pes planus in degrees; record it as mild, moderate, or severe. Indicate if orthotic devices or special footwear are used.

Item 50—Identifying Body Marks, Scars, or Tattoos. Record only scars or marks useful for identification.

Model Entry

Sibilant and sonorus rales throughout chest.

Prolonged expiration.

a. Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. disappears on exercise and deep inspiration (physiologic murmur)

b. Late soft systolic "click" heard over the second left intercostal space. parasternally, not varying in intensity with respiration, probably of cardiac origin.

Varicose veins, mild posterior superficial veins of legs. No evidence of venous insufficiency. Asymptomatic.

2.5cm linear diagonal scar right lower quadrant, well healed, no sequelae (WHNS).

Left lobe diffusely enlarged; 2cm hard, nontender nodule near isthmus.

Scoliosis, thoracic spine, minimal deviation to right.

No weakness, deformity or limitation of motion, left arm.

a. 1cm vertical linear scar, dorsum left forearm, WHNS.

b. 3cm heart-shaped tattoo, lateral aspect, middle 1/3 left forearm.

Item 51—Skin, Lymphatics. Describe pilonidal cyst or sinus, and tell whether symptomatic in past or at present. If there is a skin disease, tell what it is, record its chronicity, severity, and response to treatment in item 57. If you detect a skin disease of the face, back, or shoulders, state whether the defect will interfere with wearing an oxygen mask or whether wearing a parachute harness, shoulder straps, or other military equipment will irritate it.

Item 52—GU (Genitourinary) System. If you detect a varicocele or hydrocele, indicate the size in relation to the opposite testicle and whether it is symptomatic. If you detect an undescended testicle, describe its location, particularly in relation to the inguinal canal.

Item 53—Anus and Rectum. Check for hemorrhoids, and note size, number, and symptomatology. Check for fistula, cysts, etc. At least a visual examination is required on all examinees.

Item 54—Pelvic Examination. Perform a pelvic examination only if medically indicated. If the examination is not performed, enter "NE" in the Normal column. This examination is required for all female examinees 22 years of age and over.

Item 55—Neurologic. Record complete description of any abnormality.

Item 56—Psychiatric. Interview each applicant to evaluate level of maturity, and ability to withstand the rigorous physical and mental stresses of military service. Explain any negative recommendations in detail.

Item 57—Notes. Use this space to describe conditions found during the Clinical Evaluation (items 30 through 56). This space should be used for any other comments relating to items 10 through 29. Be sure to enter the item number before each comment. Use the back of the form, if necessary.

Item 58a—Typed or Printed Name of Examiner. The examiner identified must sign the original. Use block for Physician Assistant (PA) or Primary Care Nurse Practitioners (PCNP) who perform clinical aspect of examination.

Item 58b-Signature of Examiner.

Item 58c-Rank.

Item 58d—Corps or Degree.

Item 59a—Typed or Printed Name of Physician.

Item 59b-Rank.

Item 59c—Degree.

Model Entry

a. Acne vulgaris, mild, face, will not interfere with wearing oxygen mask or combat equipment.

b. 5×5 cm burn scar, left pretibial region. May be subject to trauma by combat boots, or breakdown by water immersion.

Varicocele, left, small, asymptomatic

One small external hemorrhoid, asymptomatic.

DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY—MALE

DOD MEDICAL EXAMINATION REV (This information is for official and medical (This form is subje	IIV co	V B	OARD (DODMERB) lential use only and will not Privacy Act of 1974 See E	REP t be r	rele	RT OF MEDICAL eased to unauthorized n 2005)	HIS'	TOR	Υ	Forn OM& Expi	n Appro 8 No. 07 res Sep	oved 704-0269 30, 1989				
NAME (Last, First, Middle Initial) MORAY, HARRY G.						011-11-000	YNU		ER			NO . (17 62-00		ea code)		
PURPOSE OF EXAMINATION EXAMINAT USAF C1	in.	ic	ACILITY OR EXAMIN Hanscom, Har	IER nsc	AI C C	nd Address (Income Fld MA C	clude .	Zip Co) 1	ode)		5	ATE OF May	EXAM 87	INATI	ON	
SECTION I - Mark applicable boxes in item	ns 1	thr	ough 10													_
1. How would you rate your present health		•			6	s. If you smoke o	igar	ette	s how many	do you	smok	ce each	day?			
X Excellent Very Good Good	Ĥ	Fa	nir Poor		Σ		_	pack	1 -1/2 p	,		acks or m				
2. How many hours sleep do you usually go	et a	t ni	ght?		7	. On the averag	je, ho)W I	nany times	per wee	k do y	you drii	nk any	alcoho	olic	
4 or less 5 6 7 X 8		_	or more	_	1	beverages suc	ch as	bee	r, wine, or li	quor?						
3. How many days per week do you exerci (enough to produce a sweat) for at least fifteen	se v	rigo nut	prously es		2	1 (Skip to item 5)		ss tha			fou			five mo	re	_
		_	6 7		ا°	3. When you drift	<u>√12</u>	UW I	many acond	Jiic 01 11 11	KS 00	you ma	s ton th		r more	
None 1 2 3 X 4	ليا	5			١,	. Have you eve		d 30	v of the foll	owing?	N/	A	لــــــــــــــــــــــــــــــــــــــ			<u> </u>
4. Are you on any special diet?		_		_	ŀ	Amphetamines			rates	Owning:	<u> </u>	emical int	halants			-
Yes X No	.41.				+	Cocaine			nogens		-	rcotic dru	·			-
5. Indicate the tobacco products you curren X Cigarettes Cigars	itiy	US4	Chewing tobacco		t	0. What is your n		_		1	7		<u> </u>			_
		Н	None (Skip to Item 7)		1	Never Married	_	arrie		ated	Div	vorced		Wi	dowe	<u> </u>
		<u>ا</u>			ب م								ary ito:		_	_
SECTION II - Mark each item (11 through ! "Yes" must be explained in the	94) he F	REN	ARKS section on the	e rev	ve	rse.	rror	a pa	ar deurar iter	ii, ieave	псога	EVE	ery iten	ari	.eu	
A. Does your family have a history of	Yes	No	C. (Contd.) Have you ev	ver ha	ad	or do you now have	Υe	s No	C. (Contd.)	Have you	ever ha	d or do yo	ou now h	ave	Yes	No
11 Diabetes or sugar diabetes	Г	Х	35. Eye trouble (exclude	glass	ses	, contact			64. Back pain	or trouble	•					×
12. Heart trouble or strokes	Γ	Х	lenses)	_	_			Х	65. Paralysis,	lameness,	or wea	kness			_	X
13. High blood pressure		Х	36. Vision change or dou	bie v	ISIC	on	\int	X	66. Foot trou	ble					X	Ĺ
14. Cancer		Х	37 Hearing loss					X	67 Rheumat	ic fever						Х
15 Mental condition		Х	38. Ear, nose, or throat to	roubl	le			X	68. Tuberculo	osis or posi	itive TB	test				X
16 Alcoholism or suicide		Х	39 Sinusitis or sinus trou	ible				X	69 Homosex	ual activity	у					X
17 Seizures or epilepsy		Х	40. Hay fever or allergic	rhind	t+s			X	70. VD, syphi	lis, gonorr	hea, he	rpes, etc.				Χ
18 Allergies or Asthma	Γ	Х	41 Severe tooth or gum	troul	ble		Σ		71 Skin cond	litions such	n as acn	e, psorias	115,		П	Γ
19 Arthritis or rheumatism		Х	42. Thyroid trouble		_		T	Х		oot rashes					\perp	X
B. Do you or did you ever			43 Chronic cough or lun	g dise	eas	se .	T	X	72. Adverse	reaction to	serum.	, drugs.			П	Γ
20. Wear glasses		Х	44. Asthma or wheezing				\top	X		, food, or b						Х
21. Wear contact lenses or ocular eye	Τ	Ť	45. Unusual shortness of	brea	th			Х	73. A weight	problem						X
retainers	Х		46. Pain or pressure in ch	nest	_		J	X	74. Recent g	ain or loss	of weig	tht			\square	Х
22 Have any allergies	Х	Γ	47 Palpitation or pound	ling h	nea	irt	T	Х	75. Excessive	bleeding	or easy	bruising				Х
23. Take any medications regularly		Х	48 Heart trouble or hear	rt mu	urm	nur		X	76. Tumor, g	rowth, cys	t, or car	ncer			\Box	Χ
24 Stutter or stammer	Γ	Х	49 High blood pressure		_		J	Х	77. Consider	ed or atter	mpted s	uicide				Χ
25 Wear a bone or joint brace or	Γ		50. Coughed up or vomit	ted b	ioc	xd		Х	78. Sleepwal	king episo	des					Х
support		x	51. Stomach, liver, or int	testin	nal	trouble	T	Х	79. Easy fatio	gability						Χ
C. Have you ever had or do you now have			52. Gailbladder trouble	or ga	list	tones		X	80. Car, train	, sea, or ai	ir sickne	255			Х	Ĺ
26 Frequent, severe, or migraine	Γ		53. Yellow jaundice or h	epati	itis			Х	81 X-ray or	other radia	ation th	erapy				Х
headaches		Х	54. Hemorrhoids or recta	al dis	eas	se		Ţχ	82. Sensitivit	ty to chem	icais, du	ust,				
27 Fainting or dizzy spells	Γ	X	55. Black or bloody stool	ls				Х	-							Х
28. Periods of unconsciousness	X		56. Frequent or painful t	urina	tio	n	\Box	Х								X
29. Head injury or skull fracture	X		57 Bed wetting since ag	je 12			$oxed{\Gamma}$	Х	D. FEM	ALES ONL	.Y – Hav	ve you ev	• N/A			E
30. Epilepsy, seizures, or convulsions	Γ	Х	58. Blood, protein, or su	garıı	n u	rine	$oldsymbol{ol}}}}}}}}}}}}}}}$	Х	84 Been tre	ated for a	female	disorder,	. ,			ľ
31. Loss of memory or amnesia		X	59. Kidney stone				\Box	Х	painful p	eriods, or	cramps				\perp	L
32. Depression, excessive worry or nervousness; anxiety		x	60. Hernia or rupture 61. Any bone or joint tro	ouble	e, b	oursitis .	\dashv	X					nant		+	-
33. Any mental condition or illness	†	Ϊ́х					十	1							T	Γ
34. Frequent trouble sleeping	†	Τ̈́	`\		_			1	_	d product			-			
E. Have you ever		4)		es N	7	E. (Contd.) Have yo	ou eve	,							Yes	N
B8. Been refused employment or been unable to hold a or stay in school because of:	job			x	1	91 Received, is there pension or comp	e pend	ling, (Х
a. Inability to perform certain movements?				×		92 Had orhaveyou	ever	been	advised to have	, any surgi	ical				1	T
b. Inability to assume certain positions?				X	-1	operations?										ķ
c. Other medical reasons?				- X	-+	93 Consulted or bee	en trea	ted b	y clinics, hospita	als, physici	ans,				\top	T
89. Been rejected for or discharged from military service	•			<u> </u>		healers, or other						· —	_		_	k
because of physical, mental or other reasons?				_X	4	94 Had any illness o	չ, յանու	y oth	er than those al	ready note	ed?					1
90. Been denied or rated up for life insurance?				_X	Ü											X

AFR160-13/AR40-29/NAVMEDCOMINST6120.2A/CGCOMDTINSTM6120.8B Attachment 3 20 October 1989

KEMARKS (Every "Yes" response in items 11 through 94 must be ex- status of the condition. Continue on a separate sheet and attach to this		ig complete details including names of do	ctors and nospitals or clinics and the current
#21 Wears hard contact lenses.			
#22 Allergiesgrass, hay and			
#28 and 29 Concussion while pl	aying football - kn	ocked out. Seen in	n emergency room at
Luke General Hospits	al, Lloyd NY, Septe	mber 1982, Dr Jones	3.
#41 Treated for gingivitis in #66 Flatfeet Treated with or	1983. No problem s	ince. Dr Fix, Mair	Street, Aspen CO.
#66 Flatfeet. Treated with or Force MA - 1984.	chotics when partic	ipating in sports.	Seen by Dr Jones,
#80 Car sickness in childhood.	I've outgrown it.	No treatment.	
I certify that I have reviewed the foregoing information of the dectors have talk or slining montioned characters.			
of the doctors, hospitals, or clinics mentioned above to my application for this employment or service.	o turnish the Government a com	npiete transcript of my medical	record for purposes of processing
	SIGNATURE		DATE SIGNED
TYPED OR PRINTED NAME OF EXAMINEE	JOHATORE		
	·	m.	
HARRY G. MORAY	Farry G.		10 Dec 88
HARRY G. MORAY NOTE: HAND TO DOCTOR OR NURSE OR IF MAILEE	Harry &.	PENED BY MEDICAL PERSONN	10 Dec 88
HARRY G. MORAY	JULLY J. D MARK ENVELOPE TO BE OF	PENED BY MEDICAL PERSONN all comment on all "Yes" and blank answ	ID Dec SS EL ONLY* ers (indicating the item number before each
HARRY G. MORAY NOTE: HAND TO DOCTOR OR NURSE OR IF MAILEE EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.)	Jakey J. D MARK ENVELOPE "TO BE OF I. PERTINENT DATA (Examiner shifting important, and record significant finding)	PENED BY MEDICAL PERSONN all comment on all "Yes" and blank array gs here. If additional space is needed, cor	ID Dec SS EL ONLY* ers (indicating the item number before each
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DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY—FEMALE

DOD MEDICAL EXAMINATION REV ("his information is for official and medical (This form is subj	liv cc	onfid	OARD (DODMERB) lential use only and will no Privacy Act of 1974 - See	ot be	e rei	ea	sed to unauthorized per	STO	ORY		Form OME Expi	n Aj R No res	pproved 0 0704-02 Sep 30, 19	69 189			
NAME (Lust, First, Middle Initial) MORAY LISA A.					T	SO	CIAL SECURITY N	UN	IBE	R			962-	. (Include a 0001	rea code)		
PURPOSE OF EXAMINATION EXAMINAT USAF C	LI	NI NI	ACILITY OR EXAMI C HANSCOM, H	nei An	SC	0	D ADDRESS (Includ M FLD MA O	e Z ₁₁		đe)				OF EXAI y 87	MINATI	ON	
SECTION !- Mark applicable boxes in item	15 1	thr	ough 10														Ц
1. How would you rate your present healt	h?				1	6.	If you smoke ciga	ret	tes	ho	w many do you	sn	noke ea	ch day?			_
X Excellent Very Good Good		Fd	nr Poor		_			1 pa	_		1-1/2 packs	L	2 packs o				_{
2. How many hours sleep do you usually g	et a	t ni	ght?		\mathbf{I}	7.	On the average,	hov	V IT	anı	times per wee	k (do you d	drink any	y alcoho	olic	- 1
4 or less 5 6 7 X 8		9	or more		┸	_	beverages such a					_	Thing or		1 10		
 How many days per week do you exerci (enough to produce a sweat) for at least fifteer 	se v	vige nut	orously es		ŀ	Х 8.	Never (skip to Item 9) When you drink,	hor	<u>. </u>		Once or twice y alcoholic drin	ks	Three or four do you	have (on	1 7 7	ge)?	ㅓ
None 1 2 3 X 4		5	6 7		1		<u> </u>	2			3	Γ	4	5		r mor	÷]
4. Are you on any special diet?					1	9.	Have you ever us	sed	an	y of	the following?		N/A				
res X No					+					ates			Chemica	Linhalants			
5. Indicate the tobacco products you curre	ntly	us	•.		1	_	Cocaine	Hall	ucin	oger	15	Г	Narcotic	drugs			
X-C-garettes Cigars			Chewing tobacco		1	10	. What is your mar	ita	sta	itus	?						
Snuff (Smokeless tobacco) Pipes	-	t	None (Skip to Item 7)		×	X	Never Married	Mai	rred		Separated	Г	Divorced	.	W	dowe	å
SECTION II - Mark each item (11 through	941	" Y.	es " or "No " If you	do	no	t k	now the answer f	or a	Da	rtic	ular item, leave	it	blank.	Every ite	m mar	ked	
"Yes" must be explained in t	he	REN	MARKS section on th	e r	eve	75	e.							•			i
A. Does your family have a history of	V = 1	No	C. (Contd.) Have you		had	ior	r do vou now have	Yes	No	c.	(Contd.) Have you	***	r had or d	o you now	have	Yes	7,0
11. Drabetes or sugar diabetes	, .,	V							Ť	_	Back pain or troub!					\top	Х
12. Heart trouble or strokes		₽	 Eye trouble (excluding fenses) 	ie gi	a 25 e.	s, c	contact		X.	65	Paralysis, lameness	, or	weakness			\top	X
13. High blood pressure	⊢	1	36. Vision change or do	uble	visi	ion	· · · · · · · · · · · · · · · · · · ·		X		Foot trouble	_				Х	
	╀	 X.	37. Hearing loss	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				-	X	_	Rheumatic fever					+	Y
14. Cancer	-	IX	38. Ear, nose, or throat	***	.5/4			Н	X	-	Tuberculosis or pos	ativ	e TR test			╁	$\frac{\Delta}{\mathbf{v}}$
15. Mental condition	⊢	X.		_				H	X	_	Homosexual activit					+	X
16. Alcoholism or suicide	╀	X.	39 Sinusitis or sinus tro		_	_		Н	$\frac{\Lambda}{X}$		VD, syphilis, gonor	_	a herner	etc		+-	X
17. Seizures or épilepsy	├-	X.	40. Hay fever or allergi	_		_		7	4	/0.	Vo. syprinis, gonon	716	a, ne pes,			+-	÷
18. Altergies or Asthma	↓_	X	41. Severe tooth or gur	m tro	ou Di	•		Х	.	71	Skin conditions suc hand or foot rasher					1	^
19. Arthritis or rheumatism	1000	X	42. Thyroid trouble				·	\vdash	X	<u> </u>	mana or root rashe	s, e.	220118, 01	Gry skill		+	-
B. Do you or did you ever			43 Chronic cough or lu		isea	se		<u> </u>	X	72	Adverse reaction to					1	١
20 Wear glasses	↓_	X.	44. Asthma or wheezin					\vdash	X	<u> </u>	medicine, food, or	Ditte	es of string	 -		+-	X
21. Wear contact lenses or ocular eye			45 Unusual shortness of		_	<u> </u>		ļ	X	┢	A weight problem					+-	X
retainers	X	┺	46. Pain or pressure in	ches	t	_		<u> </u>	X	-	Recent gain or loss					+-	X
22. Have any allergies	X	4	47. Palpitation or pour			_		_	X	_	Excessive bleeding	_		ing		+-	X
23. Take any medications regularly	丄	X	48. Heart trouble or he	art	mur	mu	ır	L_	X		Tumor, growth, cy					┰	X
24. Stutter or stammer	<u> </u>	X	49. High blood pressur	•				 	X		Considered or atte	_		<u> </u>		╀	Х
25 Wear a bone or joint brace or	1		50. Coughed up or von	ntec	blo	×	<u> </u>	L	X	-	Sleepwalking episc	ode	<u> </u>			ᅪ	X
support	L	X	51. Stomach, liver, or in	ntes	tinal	l tr	ouble	! _	Х		Easy fatigability					┰	X
C. Have you ever had or do you now have			52. Gallbladder trouble	e or	galls	sto	nes	L	Х	-	Car, train, sea, or a	_				X	↓_
26. Frequent, severe, or migraine	1	1	53. Yellow jaundice or			_		L	X	81	X-ray or other radi	atı	on therap	<u> </u>		+	X
headaches	\perp	K	54. Hemorrhoids or rec	ctalo	dise a	ase	•	\vdash	X	82	Sensitivity to chem	nica	ls, dust,				1
27. Fainting or dizzy spells	L	X	55 Black or bloody sto	ols				L	X	1_	sunlight, etc.					+	X
28. Periods of unconsciousness		4	56. Frequent or paintu	וזע וו	nati	on		L	X	83	Learning disabiliti	_				_	X
29 Head injury or skull fracture	1	<u> </u>	57 Bed wetting since a	age	12			L	X		D. FEMALES ON	LY -	- Have you	u ever			1
30 Epilepsy, seizures, or convulsions	L	\Box	58. Blood, protein, or s	suga	r in	uri	ine	L	Х	84	. Been treated for a			der,		1	l
31 Loss of memory or amnesia	I	\mathbf{L}	59. Kidney stone			_		L	X	1_	painful periods, or	rcra	mps			丄	X
32. Depression, excessive worry or	Τ	Γ	60. Hernia or rupture			_		L	X	85	Had a change in m	ens	trual patt	ern		\bot	Х
nervousness, anxiety	1		61 Any bone or joint t	troul	b'e,	bu	ursitis	Ĺ	X	96	Been pregnant or	are	you now	pregnant		4	X
33 Any mental condition or illness	Γ	\mathbf{L}	62. Broken bones or a	mpu	tatio	ons		L	Х	87	. Taken birth contri	ol po	ills (If yes.	give			Х
34 Frequent trouble sleeping	Ι	\mathbb{L}	63. Steel pins, plates, o	or st.	aple	s ir	n any bones		Х	L	dates and product					\perp	┸
E. Have you ever				Yes	No	ſ	E. (Contd.) Have you e	701	_							Ye	s [~
88. Been refused employment or been unable to hold a or stay in school because of:	job				х	ľ	91. Received, is there pe pension or compens										Х
or stay in school because of: a. Inability to perform certain movements?					X	t	92. Had, or have you ev	er b	en.	advis	ed to have, any surg	ical				T	T
b Inability to assume certain positions?		-		T	X	1	operations?				. , •						x
c Other medical reasons?				†	X	t	93. Consulted or been t	reat	ed b	y clir	ics, hospitals, physic	an	s.	 		\top	1
89 Been rejected for or discharged from military service						1					r other than minor il					\perp	k
because of physical, mental or other reasons? 90 Reen denied or rated up for life insurance?				\vdash	X	ŀ	94. Had any illness or in	gury 	oth	er th	an those already no	ted	,				X

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status of to	KS (Every "Yes" response in items 11 through 94 must be he condition. Continue on a separate sheet and attach to	o this form if additional space is needed.)	
#21	Wear soft contact lenses		
	Allergiesgrass, hay an		į
	and 29 Concussion while	playing softball - knocked out. Seen	
		ospital, Rome NY, July 1985, Dr Henry.	
#41		n 1982. No problem now. Dr Gabelman,	
#66	Flatfeet. Treated with Salem MA.	orthotics when participating in sports	. Seen by Dr Williams,
#80		d. I've outgrown it. No treatment.	Į.
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			Į.
Lectify	that I have reviewed the foregoing informa	ation supplied by me and that it is true and complete to the bes	t of my knowledge. Lauthorize any
		e to furnish the Government a complete transcript of my medic	
my appl	ication for this employment or service.		
****	OR PRINTED NAME OF EXAMINEE	Contract Contract	
TYPED	OK PRIMITED MANNE OF EXAMINATE	SIGNATURE	DATE SIGNED
		SIGNA PURE	==
LIS	A A. MORAY	Lisa A Moray	11. Lete dd
LIS.	A A. MORAY HAND TO DOCTOR OR NURSE OR IF MAI	LUCE A MICHAEL BLED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSON	ILI LEC SS
LIS.	A A. MORAY HAND TO DOCTOR OR NURSE OR IF MAI JER'S SUMMARY AND ELABORATION OF	Lisa A Moray	INEL ONLY" ISSuers (indicating the item number before each
LIS. NOTE: EXAMIN	A A. MORAY HAND TO DOCTOR OR NURSE OR IF MAI JER'S SUMMARY AND ELABORATION OF	ILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSON ALL PERTINENT DATA (Examiner shall comment on all "Yes" and blank an	INEL ONLY" ISSuers (indicating the item number before each
LIS. NOTE: EXAMIN comment). form.)	A A. MORAY HAND TO DOCTOR OR NURSE OR IF MAI IER'S SUMMARY AND ELABORATION OF develop by interview any additional medical history deel	ILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSON ALL PERTINENT DATA (Examiner shall comment on all "Yes" and blank an imed important, and record significant findings here. If additional space is needed.	INEL ONLY" INSIDER SINGLE STATE OF THE STATE
LIS. NOTE: EXAMIN comment). form.) #21 #22	A A. MORAY HAND TO DOCTOR OR NURSE OR IF MAI IER'S SUMMARY AND ELABORATION OF develop by interview any additional medical history deed Wear soft contact lenses Allergic rhinitis during	BLED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSON ALL PERTINENT DATA (Examiner shall comment on all "Yes" and blank an imed important, and record significant findings here. If additional space is needed. Lenses removed 22 days prior to exa is spring, treated with OTC medications,	INEL ONLY" ISSUED S, Indicating the item number before each continue on a separate sheet and attach to this im. Well controlled, NCNS.
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AFR160-13/AR40-29/NAVMEDCOMINST6120.2A/CGCOMDTINSTM6120.8B Attachment 3 20 October 1989

DOD MEDICAL EXAMINATION RE (This information is for official and medic (This form is sub-	illy co	ontu	OARD (DODMERB) dential use only and will no Privacy Act of 1974 - See	ot be	rel	ease	d to unauthorized pr	HST Prison	OR\	Y	I OA	48 N	pproved to 0704-026 Sep 30, 198	9			
NAME (Last, First, Middle Initial)							IAL SECURITY	NUP	ИВЕ	R	TELE	PHO	ONE NO.	(include a	rea (ode)		
PURPOSE OF EXAMINATION EXAMINA	ION	V F	ACILITY OR EXAMI	NER	A	ND	ADDRESS (Inclu	de Zi	p Co	de)			DATEC	F EXA	MINATIC	N	٦
SECTION I - Mark applicable boxes in iter	ns 1	th	rough 10	-									-				7
1. How would you rate your present healt		_			1	5 . i	ff you smoke cig	are	ttes	s h	ow many do yo	u s	moke eac	h day?]
Excellent Very Good Good		F.	air Poor		T	T	Less than 1 pack	1 p.	ock		1-1/2 packs		2 packs or	more			ℶ
2. How many hours sleep do you usually g	et a	t n	ight?		7	7. (On the average,	, ho	w IT	nai	ny times per we	ek	do you d	rink any	alcoho	lic	٦
4 or less 5 6 7 8		1	or more		1	- 1	beverages such										╝
3. How many days per week do you exerc	ise v	vig	orously		T		Never (skip to Item 9)	Les	s tha e	n	Once or twice	L	Three or four		Five more	or e	
(enough to produce a sweat) for at least fiftee	n mi	nut	tes		П		When you drink	, ho	w n	na	ny alcoholic drie	nks	do you h	ave (on 1	the averag	je)?	\Box
None 1 2 3 4		5	6 7			\perp	1	7			3		4	5	6 or	mor	e
4. Are you on any special diet?					Ŀ	9.	Have you ever u	ısed	an	y c	of the following	?					\Box
Yes No							Amphetamines	Bar	bitur	rac	rs	L	Chemical	nhalánts			_
5. Indicate the tobacco products you curre	ntly	us	е				Cocaine	Hal	lucin	109	ens	L	Narcotic d	rugs ·			ᆚ
Cigarettes Cigars		L	Chewing tobacco		Ŀ	10.	What is your ma	rita	sta	atı	us?		,				4
Snuff (Smokeless tobacco) Pipes		L	None (Skip to Item 7)		L	\perp	Never Married	Ma	rried	1	Separated	L	Divorced		Wid	owe	븨
SECTION II - Mark each item (11 through "Yes" must be explained in	94) he l	"Y REN	es " or "No." If you MARKS section on th	do r	not eve	k n	ow the answer to	for a	a pa	rt	icular item, leav	e it	blank. E	very ite	m mark	ed	١
A. Does your family have a history of	Yes	No	C. (Contd.) Have you	ever l	had	or d	lo you now have	Yes	No	c	. (Contd.) Have you	1 674	er had or do	you now	have	Yes	No
11 Diabetes or sugar diabetes	T	1	35. Eye trouble (exclud	ie ola	***		ntact	Т	П	6	4. Back pain or troub	ek					
12. Heart trouble or strokes		Τ	lenses)							6	5. Paralysis, lamenes	s, o	weakness				
13 High blood pressure	T	Т	36. Vision change or do	uble	visi	on		Т	П	6	6. Foot trouble						
14. Cancer	Т		37. Hearing loss					Т	П	6	7. Rheumatic fever						
15. Mental condition	Τ	Γ	38. Ear, nose, or throat	troul	ble			Π		6	8. Tuberculosis or po	sitiv	e TB test				
16. Alcoholism or suicide			39. Sinusitis or sinus tro	ouble				\mathbf{L}		6	9. Homosexual activ	ity					
17. Seizures or epilepsy	Τ		40. Hay fever or allergi	ic rhin	itis			Γ	П	7	0. VD, syphilis, gono	rrhe	a, herpes, e	tc.			
18. Allergies or Asthma	\prod	Γ	41 Severe tooth or gur	m tro	uble			Γ		Γ,	1. Skin conditions su	ch a	s acne, psor	asis.			l
19. Arthritis or rheumatism	L	L	42 Thyroid trouble							L	hand or foot rash	es, e	czema, or d	y skin			Ц
B. Do you or did you ever			43 Chronic cough or lu	ıng di	sea	se.				Į,	2. Adverse reaction	to se	erum, drugs,				l
20 Wear glasses	\perp	L	44. Asthma or wheezin	19				L		L	medicine, food, o	r bit	es or stings			L	Ц
21. Wear contact lenses or ocular eye		1	45 Unusual shortness of	of bre	eath	1		1	Ш	Ľ	3. A weight problem	١.					Ц
retainers	┸	L	46. Pain or pressure in	chest				1	L	Ľ	4. Recent gain or los	s of	weight			<u> </u>	Ц
22. Have any allergies	┸	Ļ	47. Palpitation or pour	nding	hea	nt		┷	↓_	Ľ	5. Excessive bleeding	g or	easy bruisin	9		<u> </u>	Ц
23. Take any medications regularly	\downarrow	╄	48. Heart trouble or he	eart m	nurr	nur		4	╄		6. Tumor, growth, c					<u> </u>	Н
24. Stutter or stammer	╀	\downarrow	49. High blood pressur	e				╀	L	+-	7. Considered or att					ļ	Ц
25. Wear a bone or joint brace or	1		50 Coughed up or von					4	Ļ	+	8 Sleepwalking epis	sode				! _	Н
support			51 Stomach, liver, or ii		_			4_	↓_	₽	9. Easy fatigability					<u> </u>	Н
C. Have you ever had or do you now have	_		52 Gallbladder trouble	_	-	_	es	4-	╄	+-	30. Car, train, sea, or					-	Н
26 Frequent, severe, or migraine	ı	ļ	53. Yellow jaundice or		_			+-	╂—	ľ	11. X-ray or other rac) sec	on therapy			╀	Н
headaches	+	╀	54. Hemorrhoids or rec 55. Black or bloody sto		isea	se		+	╀	ľ	 Sensitivity to che sunlight, etc. 	mica	ols, dust,				П
27. Fainting or dizzy spelfs 28. Periods of unconsciousness	+	╀	56. Frequent or painfu		atir	20		+	╁	+	33. Learning disabilit	ies /	or speech re-	oblems		1	Н
28. Periods of unconsciousness 29. Head injury or skull fracture	+	+	57. Bed wetting since a			<i>-</i> 11		+-	╁	k	D. FEMALES OF					2	
30. Epilepsy, seizures, or convulsions	+	╁	58. Blood, protein, or s	<u> </u>		irine	<u> </u>	+	+	ť						.	۳
31 Loss of memory or amnesia		土	59. Kidney stone	,.		_			t	1	 Been treated for painful periods, o 					L	Ц
32. Depression, excessive worry or nervousness, anxiety			60. Hernia or rupture		la l	.	:•:-	4	1	4-	86. Been pregnant o					╂-	Н
33. Any mental condition or illness	+	+	61 Any bone or joint t 62. Broken bones or a					+	+	╈						†	H
34. Frequent trouble sleeping	╁	+	63 Steel pins, plates, o				any bones	╅	+-	ď	 Taken birth continuous dates and production 			we		1	Н
E. Have you ever				Ves	_	_	(Contd.) Have you	970				-				ve.	No
88. Been refused employment or been unable to hold	job			П		-	. Received, is there p	endi	ng, c							1	
or stay in school because of: a. Inability to perform certain movements?				╁┤		92	pension or compen ! Had, or have you e					gica	.i			+	+
b. Inability to assume certain positions?				П	Г	1	operations?									1	
c Other medical reasons?				П	Г	93	Consulted or been									T	T
89. Been rejected for or discharged from military service because of physical, mental or other reasons?						\vdash					for other than minor					\vdash	\vdash
90 Been denied or rated up for life insurance?		_		\Box		Ľ	Had any illness or i	njury	oth	er i	than those already no	oted	,				

REMARKS (Every "Yes" response in Items 17 through 94 must be exp status of the condition. Continue on a separate sheet and attach to this	plained in the space below. Give dates and complete details including names of doct form if additional space is needed.)	tors and hospitals or clinic	Sano the Commit
status of the condition. Continue on a separate sneet and attach to this	form it additional space is needed)		
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I certify that I have reviewed the foregoing information	on supplied by me and that it is true and complete to the best o	f my knowledge. I	authorize any
of the doctors, hospitals, or clinics mentioned above to	furnish the Government a complete transcript of my medical i	record for purposes	of processing
my application for this employment or service.			
TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNE	0
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE	MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNI	EL ONLY"	
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL	D MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNI L PERTINENT DATA (Examiner shall comment on all "Yes" and blank answe Important, and record significant findings here. If additional space is needed, con-	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber before each
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber before each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
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NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber before each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber before each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILEI EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.)	L PERTINENT DATA (Exeminer shall comment on all "Yes" and blank answer	ers (indication the item nu	umber befinne each
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.) TYPED OR PRINTED NAME OF PHYSICIAN	L PERTINENT DATA (Examiner shall comment on all "Yes" and blank answer important, and record significant findings here. If additional space is needed, con	ers (indication the item nu	umber before each and attach to this
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILEI EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.)	L PERTINENT DATA (Examiner shall comment on all "Yes" and blank answer important, and record significant findings here. If additional space is needed, con	ers (indicating the item mi tinue on a separate sheet	umber before each and attach to this
NOTE: HAND TO DOCTOR OR NURSE OR IF MAILE! EXAMINER'S SUMMARY AND ELABORATION OF AL comment), develop by interview any additional medical history deemed form.) TYPED OR PRINTED NAME OF PHYSICIAN	L PERTINENT DATA (Examiner shall comment on all "Yes" and blank answer important, and record significant findings here. If additional space is needed, con	ers (indicating the item mi tinue on a separate sheet	umber before each and attach to this

DD Form 2492 Reverse, MAR 87

DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION

	DOD MEDICAL EXAMINATION REVI			
	Privacy Act State	ment		
AUTHORITY:	10 USC 8012 and Executive Order 9397.			
PRINCIPAL PURPOSE:	To update a medical file as part of the ap Reserve Officer Training Corps (ROTC) University of Health Sciences (USUHS).	plication pi Scholarshi	rocess to a United States Ser p Program, or the Unifor	rvice Academy, rmed Services
ROUTINE USES:	Used to determine medical acceptability USUHS, Information will be released to a The Social Security Number (SSN) is used for	uthoriz e d p	ersonnel involved in the sel	mies, ROTC, or ection process.
DISCLOSURE:	Voluntary; however, failure to furnish t process and hamper your candidacy.	he requeste	ed information will impede	the selection
1. APPLICANT'S NAME (Last,	First, Middle Initial)		2. SSN	
JONES, HARRY W.,	JR.		100-01-0001	
	INSTRUCTIONS d Examining Center by the Examining Dentist. Panorar d SSN. Expedite completed Dental Examination with of 518.	nic and bitewi		
	BELOW, RESTORABLE, NON-RESTORABLE, LACED, SPACES CLOSED AND ANY DEFECTS OR restorations)		R PRINTED NAME OF EXAMINING ALLEN, D.D.S.	DENTIST
MANA		Mark	RE OF EXAMINING DENTIST	6. DATE SIGNED
1 2 3 4 5	6 7 8 9 10 11 12 13 14 15 16	a. NAME Vanden	berg Dental Clinic	
			inic/SGD linic/SGD berg AFB CA 93437-530	0
Child X	KOLUKANIVIVIVI	NOTE: If examin	ee has a questionable occlusal relationship, fo DODMERB/DB US Academy Colorado Springs, CO 80840	-
8. GENERAL ("X" Yes or No for ea	ach question)			
b. MISSING TEE	ILES (Indicate on chart, do not chart incipiencies). TH, OTHER THAN THIRD MOLARS (Indicate on chart by ma RABLE TEETH (Indicate on chart by drawing two vertical lines throu TEETH (draw circle around the tooth on the chart and indicate positi	igh tooth).	the roots).	
——————————————————————————————————————	NTAL DISTURBANCES IN TEETH (significant enamel hypopla: TH (intrinsic) (unsightly).	sias, amelogenesis i	imperfecta, dentinogenesis imperfecta, etc.).	
	SE, TUMOR OR ANY OTHER ABNORMALITY OF THE If additional space is needed use "REMARKS" section.)	ORAL CAVIT	Y	
	AMINEE EVER HAD A CYST OR TUMOR REMOVED F ABNORMAL BLEEDING OF THE ORAL TISSUES. (Descr		OUTH OR JAWS? (If so, describe.)	
X c. ORAL ULCER X d. HISTORY OF X e. HISTORY OF				
· ·	nere an oro-nasal or oro-antral fistula present? TMJ DISEASE OR PAIN. (Describe)			

10. OCCLUSAL RELATIONSHIP ("X" Yes or No for each question) (if additional space is needed, use "REMARKS" section) YES NO			
X a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm.			
X b. ANTERIOR OVERBITE IN EXCESS OF 4mm.			
C. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.			
d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTER INTO THE LOWER LABIAL GINGIVAE.	IOR T	reeth	
X e. ANTERIOR CROSSBITE. (Describe)			i
X f. MANDIBULAR PROGNATHISM.			
X g. POSTERIOR OPEN BITE (bilateral involving more than one tooth):			
X h. POSTERIOR CROSSBITE (entire quadrant).			
X i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH.			
X j. MULTIPLE CONGENITALLY MISSING TEETH. X k. MIDLINE DEVIATION. 2 mm			
X I. ARE DENTAL STUDY CASTS BEING FORWARDED?			
11. ORTHODONTICS ("X" Yes or No for each question)			
X a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed) June 87			
X b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable).			
X c. WEARING RETAINER APPLIANCES. 21 thru 27 fixed retainer			
12. PROSTHODONTICS ("X ^a Yes or No for each question) (If additional space is needed, use "REMARKS" section.)			
X a. MISSING TEETH (prosthesis required). (Describe)			
X b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS. (Describe)			
X c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?			
13. PERIODONTAL STATUS ("X" Yes or No for each question)			
X a. MODERATE TO HEAVY CALCULUS (supra and 'or sub-gingival)			
X b. GINGIVITIS (generalized).			
X c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS.			
X d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss).			
X e. JUVENILE PERIODONTITIS.			
X f. PERICORONITIS. 14. PANOGRAPHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section).			
X a. ABNORMAL RADIOLUCENT/RADIOPAQUE AREA. (Describe) X b. IMPACTED TEETH WITH PATHOLOGY. (Describe)			
X c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe)			
X d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)			
15. OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. ("X" Yes or No)			
16. REMARKS (Indicate item of reference.) (Use additional sheet if necessary.)		ODM	ERB
13a Patient needs prophylaxis and scaling.		JSE O	
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DD Form 2480 Reverse, NOV 86

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION							
	Privacy Act States	nent					
AUTHODITY	10 USC 8012 and Executive Order 9397.	interference					
AUTHORITY: PRINCIPAL PURPOSE:							
ROUTINE USES:	Used to determine medical acceptability USUHS, Information will be released to at The Social Security Number (SSN) is used for	athorized personnel involved in the select	es, ROTC, or tion process.				
DISCLOSURE:	Voluntary; however, failure to furnish to process and hamper your candidacy.	he requested information will impede t	he selection				
1. APPLICANT'S NAME (Last, Fi	irst, Middle Initial)	2. SSN					
	INSTRUCTIONS						
To be completed at scheduled and be identified by name and Colorado Springs, Co 80840-65	Examining Center by the Examining Dentist. Panorand SSN. Expedite completed Dental Examination with c	nic and bitewing radiographs must accompany this e ompleted Medical Examination to: DODMERB/DB, t	examination US Academy,				
3. INDICATE ON THE CHART MISSING TEETH, TEETH REPL ABNORMALITIES. (Do not chart n	BELOW, RESTORABLE, NON-RESTORABLE, ACED, SPACES CLOSED AND ANY DEFECTS OR estorations)	4. TYPED OR PRINTED NAME OF EXAMINING D	ENTIST				
ABNORMALITIES. (Do not chart restorations) 5. SIGNATURE OF EXAMINING DENTIST 6. DATE SIGNED 7. EXAMINING FACILITY a. NAME NOTE: If examinee has a questionable occlusal relationship, forward diagnostic casts to: DODMERB/DB							
8. GENERAL ("X" Yes or No for ear YES NO	ch question)	<u></u>					
	IES (Indicate on chart, do not chart incipiencies).						
b. MISSING TEE	TH, OTHER THAN THIRD MOLARS (indicate on chart by ma	rking "X" through the roots).					
c. NON–RESTOR	IABLE TEETH (indicate on chart by drawing two vertical lines throu	igh tooth).					
d. UNERUPTED TEETH (draw circle around the tooth on the chart and indicate position by an arrow).							
	NTAL DISTURBANCES IN TEETH (significant enamel hypopla 	sias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.).					
f. STAINED TEETH (intrinsic) (unsightly).							
	SE, TUMOR OR ANY OTHER ABNORMALITY OF THI f additional space is needed use "REMARKS" section.)	: URAL CAVITY					
a. HAS THE EXA	AMINEE EVER HAD A CYST OR TUMOR REMOVED F	ROM THE MOUTH OR JAWS? (If so, describe.)					
b. HISTORY OF	ABNORMAL BLEEDING OF THE ORAL TISSUES. (Descri	ibe)					
	ATIONS, SOFT TISSUE LESIONS, ETC. (Describe)						
d. HISTORY OF							
e. HISTORY OF							
	nere an oro-nasal or oro-antral fistula present?						
(Continued on reverse side)							

10.	OCCLU	USAL RELATIONSHIP ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)				
YES						
	T	a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm.			-	
		b. ANTERIOR OVERBITE IN EXCESS OF 4mm.				
	\top	c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.				
		d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER A	NTERIC	R TE	ETH	
\vdash	+	e. ANTERIOR CROSSBITE. (Describe)				
	 	f. MANDIBULAR PROGNATHISM.				
	┼─	q. POSTERIOR OPEN BITE (bilateral involving more than one tooth).				
	┼──	h. POSTERIOR CROSSBITE (entire quadrant).				
	+-	i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH.				
\vdash	╁	i. MULTIPLE CONGENITALLY MISSING TEETH.				
├─	 -	k. MIDLINE DEVIATION.				
┢	┼	I. ARE DENTAL STUDY CASTS BEING FORWARDED?				
 -						
11.	ORTHO	ODONTICS ("X" Yes or No for each question)				
<u> </u>	 	a. PAST HISTORY OF ORTHODONTIC TREATMENT (date completed).				
<u> </u>	↓—	b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT (specify fixed or removable).				
	<u> </u>	c. WEARING RETAINER APPLIANCES.				
12.	PROST	THODONTICS ("X" Yes or No for each question) (if additional space is needed, use "REMARKS" section.)				
		a. MISSING TEETH (prosthesis required). (Describe)				
		b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS. (Describe)				
		c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?				
13.	PERIOD	DONTAL STATUS ("X" Yes or No for each question)				
		a. MODERATE TO HEAVY CALCULUS (supra and i or sub-gingival).				
		b. GINGIVITIS (generalized).				
		c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS.				
	1	d. LOCAL OR GENERALIZED PERIODONTITIS (with associated bone loss).				
		e. JUVENILE PERIODONTITIS.				
		f. PERICORONITIS.				
14.	PANOG	GRAPHIC RADIOGRAPH EXAMINATION ("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section).				
	T	a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. (Describe)	_			
—	1	b. IMPACTED TEETH WITH PATHOLOGY. (Pescribe)				
	1	c. IMPACTED TEETH OTHER THAN THIRD MOLARS. (Describe)				
-		d. OTHER RADIOGRAPHIC ABNORMALITIES. (Describe)				
15.	OTHER	R ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. ("X"Yes or No)				
16.	ŔEMAR	RKS (Indicate item of reference.) (Use additional sheet if necessary.)		D	DOM	:00
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DD Form 2480 Reverse, NOV 86

ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2480

Explanation	Model Entry
Item 1. Applicant Name. (Last, First, MI)	Jones, Harry W., Jr.
Item 2. Social Security Number.	999-99-9999
Item 3. Indicate on the chart: Restorable, nonrestorable, missing teeth, teeth replaced, spaces closed and any defects or abnormalities. Do not chart restorations.	See item 3, attachment 4
Item 4. Typed or Printed Name of Examining Dentist.	CHARLES P. WHITE, Maj, USAF, DC
Items 5 and 6. Signature of Examining Dentist and Date of Dental Examination.	Self-explanatory
Item 7. Examining Facility and Address.	USAF Clinic/SGD Vandenberg AFB CA 93437-5300
Items 8 through 15. A yes or no answer is required for each of the questions. Write in additional information next to the question or in the remarks section (item 16).	See items 8 through 15, attachment 4
Item 16. Remarks. Indicate item of reference, use additional sheet if necessary.	Item 13a. Patient needs prophylaxis and scaling.

DD FORM 2369, DOD MEDICAL EXAMINATION REVIEW BOARD CYCLOPEGIC REFRACTION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) CYCLOPLEGIC REFRACTION						
-	Priva	cy Act Statement				
AUTHORITY:	Title 10, USC 122, and Execu	tive Order 9397.				
PRINCIPAL PURPOSE:	To upgrade a medical file as part of the application process to a US Service Academy, Reserv Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).					
ROUTINE USE: To determine medical acceptability for one or more of the service academies, ROTC USUHS. Information will be released to authorized personnel involved in the selecti process. The social security number (SSN) is used for positive identification.						
DISCLOSURE:	Voluntary, however, failure process and hamper your ca		form	ation will impede the selection		
1. NAME OF APPLICANT (Last,	First, Middle Initial)	2. SSN OF APPLICANT	3. D/	ATE OF EXAMINATION		
SCARBOROUGH, JIMMY	r R	001-00-1000	5	May 87		
4. ADDRESS OF FACILITY (City USAFA HOSPITAL/SG	, State, Zip Code)		5. PH	IONE NO. AT FACILITY (Include Area Code)		
USAFA, CO 80840	-		(303) 472-3577		
6. CONTACT LENS DATA (X AD	plicable Item(s))		7. FA	MILY EYE HISTORY (Please indicate the		
X a. I do not wear contact			me	mbers of your immediate family who wear glasses or ttact lenses.) (X applicable item(s))		
b. Soft contact lenses w		r to the above examination	X	a. Father		
c. Hard contact lenses w		r to the above examination		b. Mother		
d. Signature of Applicar	nt		<u> </u>	c. Brother		
			X	d. Sister		
B. VISION EVALUATION REFO	RE INSTALLATION OF DROPS (Before	e cycloplegic)	<u>. </u>	e. None of my family		
a. DISTANT VISION		b. CURRENT RX N/A				
OD 20/ 20	Corr to 20/	OD Sphere Cyl		Axis		
OS 20/ 20	Corr to 20/	OS Sphere Cyl		Axis		
c. NEAR VISION		9. MEDICATION USED FOR CYCLO	PLEGI	c		
OD 20/ 20	Corr to 20/	Cyclogel				
OS 20/ 20	Corr to 20/	1				
	R CYCLOPLEGIA OBTAINED (NOTE: C ble vision. Do <u>not</u> over correct; correct only to 2		ers misse	d on 20/20, i.e., 20/20-2; 20/20-3 etc. If unable to		
a. DISTANT VISION CORRECTE		b. CYCLO RX				
OD 20/ 50	Corr to 20/ 15	OD Sphere +0.50 Cyl	-0.	50 Axis 088		
OS 20/ 50	Corr to 20/ 15	OS Sphere +0.50 Cyl				
11. REMARKS (Examiner should list any diagnosis which interferes with visual function which was noted on this examination.) 12. TYPED OR PRINTED NAME OF EXAMINER 13. SIGNATURÉ OF EXAMINER						
		(Y ₂ , /	\sim			
ISSAC L. DOETOE,	CAPT, USAF, BSC	- inachta	\sqrt{d}	10. COOP USUF		

DD Form 2369, MAY 86

Previous edition will be used

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) CYCLOPLEGIC REFRACTION **Privacy Act Statement** Title 10, USC 122, and Executive Order 9397. **AUTHORITY**: To upgrade a medical file as part of the application process to a US Service Academy, Reserve PRINCIPAL PURPOSE: Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS). To determine medical acceptability for one or more of the service academies, ROTC OR **ROUTINE USE:** USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification. **DISCLOSURE**: Voluntary, however, failure to furnish the requested information will impede the selection process and hamper your candidacy. 3. DATE OF EXAMINATION 2. SSN OF APPLICANT 1. NAME OF APPLICANT (Last, First, Middle Initial) 5. PHONE NO. AT FACILITY (Include Area Code) 4. ADDRESS OF FACILITY (City, State, Zip Code) FAMILY EYE HISTORY (Please indicate the 6. CONTACT LENS DATA (X Applicable Item(s)) members of your immediate family who wear glasses or a. I do not wear contact lenses ontact lenses.) (X applicable item(s)) b. Soft contact lenses were removed days prior to the above examination a. Father b. Mother c. Hard contact lenses were removed days prior to the above examination Brother C. d. Signature of Applicant d. Sister e. None of my family 8. VISION EVALUATION BEFORE INSTALLATION OF DROPS (Before cycloplegic) DISTANT VISION b. CURRENT RX OD 20/ Corr to 20/ **OD Sphere** Axis Axis O\$ 20/ Corr to 20/ OS Sphere NEAR VISION 9. MEDICATION USED FOR CYCLOPLEGIC OD 20/ Corr to 20/ OS 20/ Corr to 20/ 10. VISION EVALUATION AFTER CYCLOPLEGIA OBTAINED (NOTE: Correct to 20/20 absolute. Record number of letters missed on 20/20, i.e., 20/20-2; 20/20-3 etc. If unable to correct to 20/20, record best correctable vision. Do <u>not</u> over correct, correct <u>only</u> to 20/20.) a. DISTANT VISION CORRECTED TO b. CYCLO RX OD 20/ Corr to 20/ **OD Sphere** Cyl O\$ 20/ Corr to 20/ OS Sphere Cyl Axis 11.REMARKS (Examiner should list any diagnosis which interferes with visual function which was noted on this examination.) 12. TYPED OR PRINTED NAME OF EXAMINER 13. SIGNATURE OF EXAMINER

DD FORM 2370, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE-DAY BLOOD PRESSURE AND PULSE CHECK

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE DAY BLOOD PRESSURE AND PULSE CHECK

Privacy Act Statement

AUTHORITY:

Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE:

To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES:

To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The

social recurity number (SSN) is used for positive identification.

DISCLOSURE:

Voluntary; however, failure to furnish the requested information will impede the selection

process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)

MARTINEZ CATHERINE L

2. SSN OF APPLICANT

512-10-0000

INSTRUCTIONS TO EXAMINERS

Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used.

3. ARM CIRCUMFERENCE	4. WIDTH OF THE BLOOD PRESSURE CUFF	5. MEDICATION CU	RRENTLY TAKEN (If none, so state	e.)
	14 cm	NONE		
6. BLOOD PRESSURE AND F	PULSE READINGS			
a. DAY ONE		_ ;		
(1) DATE 5 Mars 9.7	(2) A.M. 0700		(3) P.M. 1300	·
5 May 87	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING	136/80	80	140/86	88
(b) RECUMBENT	138/78	78	130/80	80
(c) STANDING	130/80	78	138/82	86
D. DAY TWO				
(1) DATE 6 May 87	(2) A.M. 0715		(3) P.M. 1400	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING	120/80	80	130/70	76
(b) RECUMBENT	120/76	76	126/70	76
(c) STANDING	126/82	80	132/80	80
. DAY THREE				
1) DATE 7 May 87	(2) A.M. 0730		(3) P.M. 1500	
/ May 0/	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING	120/76	76	130/80	76
(b) RECUMBENT	118/80	76	130/80	74
(c) STANDING	124/80	80	136/86	80
. EXAMINER (Doctor/Nurse/Para				
MEDIC, JOHNNY D	IE (Last, First, Middle Initial)	b SIGNATURE	De Dic	
AlC, Blood Press	ure Recheck Department		J many	,,

DD Form 2370, MAY 85

AFR160-13/AR40-29/NAVMEDCOMINST6120.2A/CGCOMDTINSTM6120.8B Attachment 6 20 October 1989

DOD: MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE DAY BLOOD PRESSURE AND PULSE CHECK								
Privacy Act Statement								
AUTHORITY:	Title 10. US	C 133, 3012, 5031, 8012 an	d Executive Order	9397.				
PRINCIPAL PURPOSE:	•	a medical file as part of			rademy. Reserve			
PAINCIPAL POR OSE.	Officer Tra	fficer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of ealth Sciences (USUHS).						
ROUTINE USES:	Information	ne medical acceptability for will be released to autility number (SSN) is used for	horized personnel	involved in the selection	ROTC or USUHS. on process. The			
DISCLOSURE:	Voluntary; process and	however, failure to furn hamper your candidacy.	ish the requested	information will imped	de the selection			
1. NAME OF APPLICANT (La	st, First, Middle Initia	1)	2. SSN O	FAPPLICANT				
		INSTRUCTIONS 1	O EXAMINERS	**************************************				
Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used. 3. ARM CIRCUMFERENCE 4. WIDTH OF THE BLOOD PRESSURE CUFF 5. MEDICATION CURRENTLY TAKEN (If none, so state.)								
6. BLOOD PRESSURE AND	PULSE READIN	GS						
a. DAY ONE		To the second se		165-255				
(1) DATE		(2) A.M. BLOOD PRESSURE	PULSE	(3) P.M. BLOOD PRESSURE	PULSE			
(a) SITTING								
(b) RECUMBENT								
(c) STANDING								
b. DAY TWO								
(1) DATE		(2) A.M.		(3) P.M.				
(a) SITTING		BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE			
(b) RECUMBENT								
(c) STANDING								
c. DAY THREE								
(1) DATE		(2) A.M.		(3) P.M.				
		BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE			
(a) SITTING								
(b) RECUMBENT								
(c) STANDING								
7. EXAMMER (Doctor/MurselPar			1					
a. TYPED OR PRINTED NAI	VIE: (Last, First, Mide	fie Initial)	b. SIGNATURE					
c. TITLE			<u> </u>					
20.5- 3370 4444.65			····					

DD Form 2370, MAY 85

DD FORM 2371. DOD MEDICAL EXAMINATION REVIEW BOARD

(DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION							
1	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION						
	Privacy Act S	tatement					
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 an	d Executive Order 9397					
PRINCIPAL PURPOSE:	To upgrade a medical file as part of t Officer Training Corps (ROTC) Schola Health Sciences (USUHS).						
ROUTINE USE:	To determine medical acceptability for Information will be released to auth Social Security number (SSN) is used for	norized personnel invol	ved in the selection process. The				
DISCLOSURE:	Voluntary; however, failure to furni process and hamper your candidacy.	ish the requested infor	rmation will impede the selection				
1. TYPED OR PRINTED NAM	AE OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR				
LEWIS, JOHN D.		001-01-1001	US Naval Academy				
Service Academy medic year's selection cycle. previous examination r 4. "I hereby certify the	INSTRUCT Defense Medical Examination Review al examination report. Our records in If there has been no change in your report as the basis for determining your nat I have not received any medical of	w Board (DODMERB) h dicate that you were gi medical or dental cond medical or dental statu	ven a medical examination for last ition, we may be able to use your is for the current selection cycle.				
medical examination. The above statement	n."		·				
<u> </u>	ACCURATE in all respects.						
	.LY ACCURATE (Explain in detail in 4b below						
			additional pages if necessary)				
b. Detailed explanation why the statement in 4 above is not totally accurate (Attach additional pages, if necessary.) I had two wisdom teeth removed in Jan 86. I had arthoscopic surgery on my right knee in Nov 85. My knee is fine now.							
	In P Lewis		6. DATE SIGNED 6 May 87				
<u> </u>	M & CATTAC		I (O Y ! IQU X')				

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION							
	Privacy A	ct Statement					
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012	2 and Executive Order 939	7.				
PRINCIPAL PURPOSE:	To upgrade a medical file as part of Officer Training Corps (ROTC) Schealth Sciences (USUHS).	of the application process holarship Programs, or th	s to a U.S. Service Academy, Reserve ne Uniformed Services University of				
ROUTINE USE:		authorized personnel inve	service academies, ROTC or USUHS. olved in the selection process. The on.				
DISCLOSURE:	Voluntary; however, failure to for process and hamper your candidate.		ormation will impede the selection				
1. TYPED OR PRINTED NAI	ME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR				
	INSTR	UCTIONS					
Service Academy medion year's selection cycle. previous examination records.	cal examination report. Our record	s indicate that you were our medical or dental con your medical or dental star					
medical examination a. The above stateme	on."	al or dental care since tr	ne date of my Service Academy				
(1) IS TRUE AND	ACCURATE in all respects.	•					
(2) IS NOT TOTA	LLY ACCURATE (Explain in detail in 4b t	below.)					
(2) IS NOT TOTALLY ACCURATE (Explain in detail in 4b below.) b. Detailed explanation why the statement in 4 above is not totally accurate (Attach additional pages, if necessary.)							
5. SIGNATURE OF APPLICA	NT		6. DATE SIGNED				
DD Form 2371 MAY 85							

DD FORM 2372, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH

		AMINATION REVIEW BO				
		Privacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5	5031, 8012 and Executiv	e Order 9397.			
PRINCIPAL PURPOSE:	To update a medical file Officer Training Corps (Health Sciences (USUHS)	(ROTC) Scholarship Prog	tion process to a U.S grams, or the Unifor	. Service Academy, Reserve rmed Services University of		
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC OR USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.					
DISCLOSURE:	Voluntary; however, fa process and hamper you		quested information	will impede the selection		
1. NAME OF APPLICANT (La	t, First, Middle Initial)			2. SSN OF APPLICANT		
STEWART, ANN M.				001-02-1002		
3. STATEMENT OF PRESENT	HEALTH					
Good.						
4. NAME OF MEDICATION(S) AND REASON FOR TAKING (f you are not on any kind of medication	is, simply state "NONE.")			
Tetracycline for	my acne.					
S. DO YOU HAVE ALLERGI	5? (Answer Yes or No. If yes, indicate t	treatment received; if no allergies, w	rite "NONE.")			
						
			·····			
1						
6. REMARKS						
	<u> </u>					
-						
7. SIGNATURE OF APPLICAN	τ ,			8. DATE SIGNED		
Unn 7	n Stewn	£		6 May 87		
DD Form 2372, FEB 86		Previous edition may be use	od.			

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH				
	Privacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).					
ROUTINE USE:	UTINE USE: To determine medical acceptability for one or more of the service academies, ROTC OR USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.				
<u>DISCLOSURE</u> :	Voluntary; however, failure to furnish the requested information process and hamper your candidacy.	will impede the selection			
1. NAME OF APPLICANT (Las	st, First, Middle Initial)	2. SSN OF APPLICANT			
3. STATEMENT OF PRESENT	HEALTH				
4. NAME OF MEDICATION(S	5) AND REASON FOR TAKING (If you are not on any kind of medications, simply state "NONE.")				
5. DO YOU HAVE ALLERGI	ES? (Answer Yes or No. If yes, indicate treatment received; if no allergies, write "NONE.")				
6. REMARKS					
7. SIGNATURE OF APPLICA	NT	8. DATE SIGNED			
[1			

DD Form 2372, FEB 86

Previous edition may be used.

DD FORM 2374, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) HEART MURMUR EVALUATION

		MINATION REVIEW BOARD (DODMERS IURMUR EVALUATION	3)		
	Pr	ivacy Act Statement			
AUTHORITY:	Title 10, USC 133, 3012, 50	31, 8012 and Executive Order 9397.			
PRINCIPAL PURPOSE:	- 				
ROUTINE USE:	Information will be release	eptability for one or more of the service sed to authorized personnel involved N) is used for positive identification.	te academies, ROTC or USUHS. in the selection process. The		
DISCLOSURE:	Voluntary; however, failu process and hamper your o	are to furnish the requested informat candidacy.	ion will impede the selection		
1. NAME OF APPLICANT (La	st, First, Middle Initial)		2. SSN OF APPLICANT		
MALIK, BONITA A			111-11-1111		
	INSTRI	UCTIONS TO EXAMINER			
of "innocent" or "func Defense Medical Exam	tional" murmurs. We reque ination Review Board to mak	cuspid aortic valve are being found inc est that you complete this form which ke a proper determination of the applic	will enable the Department of cant's cardiac status.		
3. GRADE, AMPLITUDE OR	, , , , , , , , , , , , , , , , , , , ,	4. LOCATION (Where is the sound heard bes	rt?)		
Grade I/VI Systo 5. TIMING DURING THE CAI		Apex			
Mid Systolic 6. CHARACTER OF THE SOL Decresendo	IND (e.g., crescendo-decrescendo)				
7. RADIATION OR TRANSMI	SSION OF THE SOUND				
None					
8. OTHER SOUNDS (e.g., click)					
Mid Systolic Clic	ck				
9. RESULT OF ECHOCARDIO	GRAM (Please attach results - NOT TRACIN	(GS.)			
Mitral Valve Pro DOPPLER: No evid	lapse, minimal dence of mitral regurg	itation			
10. FINAL IMPRESSION AND	OTHER COMMENTS				
_	by P.E. and by echo.				
11. EXAMINING PHYSICIAN					
a. TYPED OR PRINTED NAME (Last Lowe, John E	, First, Middle Initial)	b SIGNATURE	c DATE SIGNED 7 May 87		
DD Form 2374, MAY 85		Jan Cy B			

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) HEART MURMUR EVALUATION					
	<u>Pri</u>	vacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 503	31, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:		s part of the application process to a L DTC) Scholarship Programs, or the Uni				
ROUTINE USE:	Information will be releas	eptability for one or more of the service ed to authorized personnel involved i I) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failu process and hamper your c	re to furnish the requested informati andidacy.	on will imped	de the selection		
1. NAME OF APPLICANT (Las	t, First, Middle Initial)		2. SSN OF APP	LICANT		
	INSTRU	ICTIONS TO EXAMINER				
of "innocent" or "func	tional" murmurs. We reque	cuspid aortic valve are being found incr st that you complete this form which v e a proper determination of the applic	vill enable the	Department of		
3. GRADE, AMPLITUDE OR I	NTENSITY (Use the I-VI Scale)	4. LOCATION (Where is the sound heard best	?)			
5. TIMING DURING THE CAR	RDIAC CYCLE (e.g., mid-systole)		····			
6. CHARACTER OF THE SOU	ND (e.g., crescendo-decrescendo)					
7. RADIATION OR TRANSMI	SSION OF THE SOUND					
8. OTHER SOUNDS (e.g., click)			-			
9. RESULT OF ECHOCARDIO	GRAM (Please attach results - NOT TRACIN	GS.)				
ļ						
10. FINAL IMPRESSION AND OTHER COMMENTS						
				l		
		The second secon				
11. EXAMINING PHYSICIAN a. TYPED OR PRINTED NAME (Lass	t First Middle Initial)	b. SIGNATURE		c. DATE SIGNED		
G. TITED ON PRINTED NAME (LES	yy mineris millery			S POIS NOMED		

DD Form 2374, MAY 85

DD FORM 2375,

DOD

PULMONARY

EXAMINATION REVIEW

BOARD

(DODMERB)

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) PULMONARY FUNCTION STUDIES

Privacy Act Statement

AUTHORITY:

Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE:

To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC)

Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USE:

To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to

authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE:

Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)

DOE, JOHN E

2. SSN OF APPLICANT

000-00-0001

7 May 87

4. PRIOR TO EXERCISING PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE/

5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL

4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE/
THEOPHYLLINE TEST

Theophylline level: 0 ng/ml

Normal therapeutic range 10-20 ng/ml

6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED

ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF
THE EXERCISE. STATE DURATION OF EXERCISE

10 mins

NOTE: Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter.

		TEST RESULTS						
	a. BEFORE EXERCISE			b. AFT	ER EXERCISE	c. AFTER BRONCHODILATOR		
	NORMAL (1)	% PREDICTED (2)		NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	
7. TOTAL VITAL CAPACITY	4.50	89%	4.30		85%	4.55	90%	
3. FEV-1.0	3.97	94%	3.73		89%	4.08	97%	
. MEFR 25 - 75 %	4.42	87%	3.99		78%	5.01	98%	
0. WAS WHEEZING PRESENT	YES	NO	11. IS THE PATIENT TAKING ANY MEDICATIONS? (x one)					
			a. YES (Specify medications and usage)					
a. BEFORE EXERCISE		X						
b. AFTER EXERCISE		X		XX b. NO				
AFTER BRONCHODILATOR		X	XX					
2 FYAMINER								

12. EXAMINER

TYPED OR PRINTED NAME (Last, First, Middle Initial)

Wally, Edward P

b. SIGNATURE

TITLE

Chief, Pulmonary Clinic, WBAMC, EP, TX

DD Form 2375, MAY 85

			ICAL EXAMINATION MONARY FU				
			Privacy Act	Statement			
AUTHORITY:	Title 10, USC 133	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.					
PRINCIPAL PURPOSE:	To update a mo Scholarship Prog	edical file as part rams, or the Unifo	t of the application rmed Services Unive	n process to a U.S ersity of Health Scie	. Service Academy, R nces (USUHS).	eserve Officer Trainir	ng Corps (ROTC)
ROUTINE USE:	To determine mauthorized person	nedical acceptabili connel involved in t	ty for one or more he selection process.	of the service acc The social security	ademies, ROTC or USI number (SSN) is used	JHS. Information will for positive identificat	I be released to tion.
DISCLOSURE:	Voluntary; howe	ever, failure to fur	nish the requested ir	nformation will imp	ede the selection prod	ess and hamper your o	candidacy.
1. NAME OF APPLICANT (Las	st, First, Middle Initial)			2. SSN OF APPLICAN	i T	3. DATE OF EXAMINAT	ION
4. PRIOR TO EXERCISING, F THEOPHYLLINE TEST 6. VIGOROUS EXERCISE TO ON A TREADMILL. PERFI THE EXERCISE. STATE D	CONSIST OF 8 TO 10) MINUTES OF RUNNI TEST IMMEDIATELY U	NG. THIS EXERCISE MA		1	the bronchodilator 4 minut e function test one minute t	
			TEST	RESULTS			
		a. BEFORE	EXERCISE	b. AF	TER EXERCISE	c. AFTER BRON	CHODILATOR
		NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
7. TOTAL VITAL CAPACITY							
8. FEV-1.0							
9. MEFR 25-75 %							
10. WAS WHEEZING PRESEN	T	YES	NO	11. IS THE PATIENT	TAKING ANY MEDICATION	IS? (x one)	
a BEFORE EXERCISE			 	a. YES (Specify me	dications and usage)		
b. AFTER EXERCISE							
c. AFTER BRONCHODILATOR			İ	b. NO			
12. EXAMINER							
a. TYPED OR PRINTED NAME (Las	t, First, Middle Initial)			b. SIGNATURE			
c. 11TLE							

DD FORM 2377, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED / GREEN COLOR VISION TEST					
	Privacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Ord	ler 9397.			
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish the request process and hamper your candidacy.	ted information will impede the selection			
1. NAME OF APPLICANT (ast, First, Middle Initial)	2. SOCIAL SECURITY NUMBER OF APPLICANT			
FRELIX, ROSS L.		900-00-0009			
3. "I certify that Applicant (Examinee) (X One) XX a. CAN b. CAN NOT distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. (Do not readminister standard color vision test.)					
4. EXAMINER					
b. SIGNATURE OF EXAMINER Color Vision Specialist b. SIGNATURE OF EXAMINER c. DATE SIGNED 7 May 87					

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST					
	Privacy Act State	<u>ment</u>			
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Exe	cutive Order 9397.			
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.				
1. NAME OF APPLICANT (ast, First, Middle Initial)	2. SOCIAL SECURITY N	UMBER OF APPLICANT		
3. "I certify that Application of the distinguish and ide paper. (Do not readm	icant (Examinee) (X One) a. CAN ntify Objects that are bright RED and bright inister standard color vision test.)	b. CAN NOT	ed balls, construction		
4. EXAMMER					
a. TITLE OF EXAMINER	b. SIGNATURE OF EXAMINER		c. DATE SIGNED		
DD Form 2377, MAY 8!					

DD FORM 2378, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEADACHES

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

S	TATEMENT OF	HISTORY	REGARDING	HEADACHES		
		Privacy Act	Statement			
AUTHORITY:	Title 10, USC 133, 3012	, 5031, 8 012 a	and Executive Order	9397.		
PRINCIPAL PURPOSE:	Officer Training Corps	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USE:	To determine medical Information will be re social security number	leased to au	thorized personnel	the service academies, ROTC or USUHS involved in the selection process. The cation.		
DISCLOSURE:	Voluntary; however, for process and hamper you	failure to fur our candidacy	nish the requested	information will impede the selection		
		INSTRU	CTIONS			
additional space is need	ded, please use reverse si	de of this for	m.	thes. Be very specific in your answers. If		
1. HOW OFTEN DO YOUR H Once a month.	EADACHES OCCUR? (e.g., mon	thly, quarterly, every	six months, etc.)			
I						
Once a day.	JR, WHAT IS THEIR FREQUEN	CY? (e.g., once a di	ay, twice, three times, etc.)			
			·			
2 hours	DACHES USUALLY LAST? (e.	g., 1 hour, 2 hours, 6 h	ours, etc.)			
4. HAVE YOU EVER TAKEN	ANY MEDICATIONS FOR YOU	IR HEADACHES	P IF SO, PLEASE EXPLA	IN IN DETAIL (e.g., what medication, usual dose, etc.)		
Tylenol						
	RE WITH NORMAL ACTIVITIES	5?				
No						
6. LIST ANY OTHER PERTINE	NT INFORMATION CONCERN	ING THIS PROBL	EM			
7. HAS A PHYSICIAN DIAGN	OSED YOUR HEADACHES?	F SO, WHAT W	ERE THE FINDINGS?			
Tension headacl						
				•		
a. SIGNATURE			h social sections and	R C. DATE SIGNED		
Kan No	mol		b. SOCIAL SECURITY NUMBER	5 May 87		
D Form 2279 MAY 95						

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEADACHES							
	Privacy Act	<u>Statement</u>					
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 a	nd Executive Order 9397.					
PRINCIPAL PURPOSE:		To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of					
ROUTINE USE:	To determine medical acceptability Information will be released to aut social security number (SSN) is used f	horized personnel involved in t					
DISCLOSURE:	Voluntary; however, failure to furr process and hamper your candidacy.	nish the requested information	will impede the selection				
	INSTRUC	TIONS					
Please provide the additional space is need	following information concerning you ded, please use reverse side of this form	r history of headaches. Be very s n.	pecific in your answers. If				
1. HOW OFTEN DO YOUR H	HEADACHES OCCUR? (e.g., monthly, quarterly, every s	= months, etc)					
2. WHEN HEADACHES OCCU	UR, WHAT IS THEIR FREQUENCY? (e.g., once a da	r, twice, three times, etc.)					
3. HOW LONG DO THE HEA	ADACHES USUALLY LAST? (e.g., 1 hour, 2 hours, 6 ho	urs, etc.)					
4. HAVE YOU EVER TAKEN	ANY MEDICATIONS FOR YOUR HEADACHES?	IF SO, PLEASE EXPLAIN IN DETAIL (e.g	g, what medication, usual dose, etc)				
5. DO HEADACHES INTERFE	RE WITH NORMAL ACTIVITIES?						
6. LIST ANY OTHER PERTIN	ENT INFORMATION CONCERNING THIS PROBL	EM					
7. HAS A PHYSICIAN DIAGR	NOSED YOUR HEADACHES? IF SO, WHAT W	RE THE FINDINGS?					
	, , , , , , , , , , , , , , , , , , , ,	***					
8. APPLICANT							
a SIGNATURE		b SOCIAL SECURITY NUMBER	c. DATE SIGNED				

DD Form 2378, MAY 85

DD FORM 2379, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEAD INJURY

	DOD MEDICAL EXAMINATION REVIEW BOARD (DO STATEMENT OF HISTORY REGARDING HE				
	Privacy Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:	To update a medical file as part of the application proce Officer Training Corps (ROTC) Scholarship Programs, or t Health Sciences (USUHS).	ss to a US Service Academy, Reserve he Uniformed Services University of			
ROUTINE USES:	To determine medical acceptability for one or more of the Information will be released to authorized personnel invisocial security number (SSN) is used for positive identification	olved in the selection process. The			
DISCLOSURE:	Voluntary; however, failure to furnish the requested interprocess and hamper your candidacy.	formation will impede the selection			
1. NAME OF APPLICANT (L	ast, First, Middle Initial)	2. SSN OF APPLICANT			
BENNETT, TERRY	J.	001-11-1011			
	INSTRUCTIONS				
needed, use the revers		your answers. If additional space is			
3. HOW DID THE HEAD IN Playing football	NJURY OCCUR?				
4. HOW OLD WERE YOU V	WHEN IT HAPPENED?				
15 years old					
5. WERE YOU UNCONSCIO yes, 2 minutes	US? HOW LONG?				
6. DID YOU HAVE A SKUL No	L FRACTURE?				
7. DID YOU HAVE ANY S ETC.? HOW LONG DID	YMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, VOMITII THE SYMPTOM(S) LAST?	NG, AMNESIA, DOUBLE VISION, DIZZINESS,			
Dizziness for 5	minutes.				
8. WERE ANY ADDITIONAL PNEUMOENCEPHALOGRA	L PROCEDURES ACCOMPLISHED SUCH AS ELECTROENCEPHAL AM, ETC.?	OGRAM, BRAIN SCAN, BURR HOLES,			
Skull x-rays whi	ich were normal.				
9. SIGNATURE OF APPLICA	ANT	10. DATE SIGNED			
TOAL OF	2000	7 May 87			
DD Form 2379, MAY 85	· · · · · · · · · · · · · · · · · · ·	<u> </u>			

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEAD INJURY					
	Privacy Act S	tatement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and	Executive Order 939	77 .			
PRINCIPAL PURPOSE:	To update a medical file as part of the Officer Training Corps (ROTC) Scholar Health Sciences (USUHS).	e application proce ship Programs, or t	ss to a US Service Academy, Reserve the Uniformed Services University of			
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.					
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.					
1. NAME OF APPLICANT (Last, First, Middle Initial)		2. SSN OF APPLICANT			
	INCTRICT	IONE				
needed, use the revers			your answers. If additional space is			
3. HOW DID THE HEAD I	NJURY OCCUR?					
4. HOW OLD WERE YOU	WHEN IT HAPPENED?					
5. WERE YOU UNCONSCIO	DUS? HOW LONG?					
6. DID YOU HAVE A SKU	LL FRACTURE?					
7. DID YOU HAVE ANY ETC.? HOW LONG DID	SYMPTOMS AFTER THE INJURY, FOR EXAMPLE THE SYMPTOM(S) LAST?	; HEADACHES, VOMITI	NG, AMNESIA, DOUBLE VISION, DIZZINESS,			
8. WERE ANY ADDITIONAL PNEUMOENCEPHALOGR	AL PROCEDURES ACCOMPLISHED SUCH A	AS ELECTROENCEPHAL	OGRAM, BRAIN SCAN, BURR HOLES,			
9. SIGNATURE OF APPLIC	ANT		10. DATE SIGNED			

DD Form 2379, MAY 85

DD FORM 2380, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING

Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services Un Health Sciences (USUHS). ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC Information will be released to authorized personnel involved in the selection prosocial security number (SSN) is used for positive identification.	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING					
To update a medical file as part of the application process to a US Service Academ Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services Un Health Sciences (USUHS). ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC Information will be released to authorized personnel involved in the selection process are useful for the service academies, ROTC Information will be released to authorized personnel involved in the selection process and hamper your candidacy. Voluntary; however, failure to furnish the requested information will impede the process and hamper your candidacy. 1. NAME OF APPLICANT (Lest First, Modele initial) TIPTOE, JOHNNY T. 1. NAME OF APPLICANT (Lest First, Modele initial) INSTRUCTIONS Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (app)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in				· · · · · · · · · · · · · · · · · · ·		
Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services Un Health Sciences (USUHS). ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC Information will be released to authorized personnel involved in the selection prosocial security number (SSN) is used for positive identification. DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the process and hamper your candidacy. 1. NAME OF APPLICANT (a.sat. First. Middle Initial) TIPTOE, JOHNNY T. INSTRUCTIONS Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in	THORITY:	itle 10, USC 133, 3012, 5031, <mark>8012 and Exe</mark>	cutive Order 9	1397 .		
Information will be released to authorized personnel involved in the selection prosocial security number (SSN) is used for positive identification. DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the process and hamper your candidacy. 1. NAME OF APPLICANT (Lest. First. Amiddle Initial) TIPTOE, JOHNNY T. INSTRUCTIONS Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in		To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of				
process and hamper your candidacy. 1. NAME OF APPLICANT (Last, First, Middle Initial) TIPTOE, JOHNNY T. 100-01-1000 INSTRUCTIONS Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room. I wake up in	1	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
INSTRUCTIONS Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room. I wake up in		Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.				
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Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in	TIPTOE, JOHN	TY T.		100-01-1000		
Please answer the following questions regarding sleepwalking. Be very specific in your answers. If addition needed, use the reverse side of this form. 3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING? Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in		INSTRUCTIONS				
Twice a month 4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)? April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room. I wake up in	ase answer the following deded, use the reverse side.	g questions regarding sleepwalking. Be	very specific in	n your answers. If additional spac		
April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in		DES OF SLEEPWALKING?				
April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in	· · · · · · · · · · · · · · · · · · ·					
April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in						
April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in						
April 1987, 17 years old 5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in						
5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING. I get up in the middle of the night and walk into the living room, I wake up in	WHEN DID YOU LAST SLEEP	WALK (month and year) (age)?		**		
I get up in the middle of the night and walk into the living room. I wake up in	April 1987, 17 yea	rs old				
I get up in the middle of the night and walk into the living room. I wake up in						
I get up in the middle of the night and walk into the living room. I wake up in						
				room I wake up in		
the living room and don't remember how I got there.				TOOM: I wake up In		
	the living room a	d don't remember how I got there	≘			
				· · · · · · · · · · · · · · · · · · ·		
	·			····		
				·		
6. SIGNATURE OF APPLICANT 7. DATE SIGNED	SIGNATURE OF APPLICANT			7. DATE SIGNED		
1 May 87 DD Form 2380, MAY 85	Johnny 1	Tightel		1 May 87		

ST	DOD MEDICAL EXAMINATION REVIEW TATEMENT OF HISTORY REGARD		
	Privacy Act Statemer	nt	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Exec	 :utive Order 9	9397 .
PRINCIPAL PURPOSE:	To update a medical file as part of the app Officer Training Corps (ROTC) Scholarship I Health Sciences (USUHS).	lication proc	ess to a US Service Academy, Reserve
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.		
DISCLOSURE:	Voluntary; however, failure to furnish the process and hamper your candidacy.	requested in	oformation will impede the selection
1. NAME OF APPLICANT (Last	t, First, Middle Initial)		2. SSN OF APPLICANT
Please answer the follow needed, use the reverse	INSTRUCTIONS wing questions regarding sleepwalking. Be viside of this form.	ery specific in	n your answers. If additional space is
3. HOW FREQUENT ARE EPIS	SODES OF SLEEPWALKING?		
		· · · · · · · · · · · · · · · · · · ·	
4. WHEN DID YOU LAST SLE	EPWALK (month and year) (age)?		
5. PROVIDE ANY OTHER PER	RTINENT INFORMATION RELATED TO YOUR SLEEPWALE	KING.	

			Made and the second second second second second second second second second second second second second second
			
6. SIGNATURE OF APPLICAN	i T		7. DATE SIGNED

DD Form 2380, MAY 85

DD FORM 2381, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING MOTION SICKNESS

ST	DOD MEDICAL EXAMINATI ATEMENT OF HISTORY R					
	Privacy .	Act Statement				
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).					
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.					
DISCLOSURE:	Voluntary; however, failure to f process and hamper your candidate	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.				
1. NAME OF APPLICANT	Last, First, Middle Initial)	· · · · · · · · · · · · · · · · · · ·	2. SSN OF APPLICANT			
MELLS, FRED D.			100-00-0010			
	INST	RUCTIONS	L			
needed, use the revers	owing questions regarding motion sees ide of this form.	sickness. Be very specific	in your answers. If additional space is			
3. TYPE OF MOTION SICK	NESS (SUCH AS, AIR, TRAIN, CAR, SEA, SW	ING, CARNIVAL RIDES, ETC.).				
Sea sickness		·				
		·				
4. WHAT AGE DID IT FIRS	T HAPPEN?					
14 years old						
	.					
5. HOW SEVERE AND FRE						
I was sick all	day while deep sea fishing	. This happened on	ly once.			
						
	ERTINENT INFORMATION RELATED TO YO					
I have gone fi	shing since and not gotten	sea sick.				
7. SIGNATURE OF APPLICA	ANT		8. DATE SIGNED			
Jud D	mells)		2 Apr 87			
D Form 2381, MAY 85						

STA	DOD MEDICAL EXAMINATION RE ATEMENT OF HISTORY REGA				
	Privacy Act Sta	<u>tement</u>			
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.				
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).				
ROUTINE USES:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.				
DISCLOSURE:	Voluntary; however, failure to furnish process and hamper your candidacy.	the requested info	ormation will impede the selection		
1. NAME OF APPLICANT	Last, First, Middle Initial)		2. SSN OF APPLICANT		
	INSTRUCTIO)NS			
needed, use the revers	owing questions regarding motion sicknes se side of this form.	s. Be very specific i	n your answers. If additional space is		
3. TYPE OF MOTION SICK	NESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CA	RNIVAL RIDES, ETC.).			
4. WHAT AGE DID IT FIRS	T HAPPEN?	<u></u>			

5. HOW SEVERE AND FRE	QUENT ARE EPISODES?				
6. PROVIDE ANY OTHER	PERTINENT INFORMATION RELATED TO YOUR MO	TION SICKNESS.			

7. SIGNATURE OF APPLIC	ANT		8. DATE SIGNED		
DD Form 2381, MAY 8	:5				

DD FORM 2382, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES

STATEMENT OF	DOD MEDICAL EXAMINATION REVIE HISTORY REGARDING HAY FEVER,	W BOARD (DODMERB) SINUSITIS, ASTHMA AND/OR ALLERGIES
	Privacy Act States	nent
AUTHORITY:	Title 10, US Code 133, 3012, 5031, 8012 and	EO 9397, November 1943 (SSN).
PRINCIPAL PURPOSE:	To update a medical file as part of the ap Officer Training Corps (ROTC) Scholarship Health Sciences (USUHS).	oplication process to a US Service Academy, Reserve o Programs, or the Uniformed Services University of
ROUTINE USES:		e or more of the service academies, ROTC or USUHS. ed personnel involved in the selection process. The sitive identification.
DISCLOSURE:	Voluntary; however, failure to furnish the process and hamper your candidacy.	ne requested information will impede the selection
1. NAME OF APPLICANT (La	it, First, Middle Initial)	2. SSN OF APPLICANT
MARPEL, MARY M.		000-01-0000
	INSTRUCTIONS	
answers. If additional s	owing questions regarding hay fever, sinusi pace is needed, use the reverse side of this f	tis, asthma and/or allergies. Be very specific in your orm.
-	lay 85, 14 July 85, 1 October 85,	30 January 86 and 14 Apr 87.
		the state of the s
4. SIGNS, SYMPTOMS AND Wheezing, shortne		
5. TYPE AND AMOUNT OF	MEDICATION USED AND LENGTH OF TREATMENT.	
Theodur 300 mgs,	3 times a day for 30 days.	
6. TYPE OF AND DURATION N/A	OF HYPOSENSITIZATION (DESENSITIZATION) (IF AN	IY) EMPLOYED, GIVING INCLUSIVE DATES.
21/21		
7. HAS MAINTENANCE DOS	E BEEN ATTAINED?	
	led prior to exercises.	
 AGE AT LAST ATTACK O 16 years old 	F ASTHMA AND DATE LAST ASTHMA MEDICATION	WAS USED.
	OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXPL	AIN.
No		
200		
10.SIGNATURE OF APPLICA DD Form 2382, MAY 87	M Margel	11. DATE SIGNED 14 -May 87
DD FORM 2382, NIA 7 8/	Previous edition m	ay de used.

STATEMENT OF	DOD MEDICAL EXAMINATION REVIEW I	BOARD (DODMERB) NUSITIS, ASTHMA AND/OR ALLERGIES					
	Privacy Act Statemen	<u>rt</u>					
AUTHORITY:	Title 10, US Code 133, 3012, 5031, 8012 and EC	9397, November 1943 (SSN).					
PRINCIPAL PURPOSE:		To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of					
ROUTINE USES:	To determine medical acceptability for one of Information will be released to authorized particles social security number (SSN) is used for positive	r more of the service academies, ROTC or USUHS. personnel involved in the selection process. The eidentification.					
DISCLOSURE:	Voluntary; however, failure to furnish the r process and hamper your candidacy.	equested information will impede the selection					
1. NAME OF APPLICANT (L.	ist, First, Middle Initial)	2. SSN OF APPLICANT					
	INSTRUCTIONS						
	owing questions regarding hay fever, sinusitis, space is needed, use the reverse side of this form	asthma and/or allergies. Be very specific in your n.					
3. NUMBER AND APPROXI	MATE DATES OF ATTACKS OR EPISODES.						
4. SIGNS, SYMPTOMS AND	DURATION OF ATTACKS.						
:							
5. TYPE AND AMOUNT OF	MEDICATION USED AND LENGTH OF TREATMENT.						
6 TYPE OF AND DURATIO	N OF HYPOSENSITIZATION (DESENSITIZATION) (IF ANY) E	MINOVED GIVING INCLUSIVE DATES					
U. TITE OF AND BORATIO	TO THE SEASON (SESSION) (IF ANY)						
7. HAS MAINTENANCE DO	SE BEEN ATTAINED?						
	OF ASTHMA AND DATE LAST ASTHMA MEDICATION WA	S USED					
	OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXPLAIN.						
3. 13 THERE ART HISTORY	OF ALLENDIC SKIN DISONDER: IF TES, FLEASE EAFLAIN.						
10. SIGNATURE OF APPLICA	.NT	11.DATE SIGNED					
DD Form 2292 MAN 97							

DD Form 2382, MAY 87

Previous edition may be used

DD FORM 2383, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATION

	DOD MEDICAL EXAMINATION REVIEW BOASTATEMENT OF USE REGARDING		N				
	Privacy Act Statement						
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.						
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).						
ROUTINE USE:	To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.						
DISCLOSURE:	Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.						
1. NAME OF APPLICANT (Las	, First, Middle Initial)		2. SSN OF APPLICANT				
WHITE, REBECCA	L.		010-00-1010				
	INSTRUCTIONS						
Please answer the f	ollowing questions regarding use of medication.	Re very specific i= :	COUR anguage If addition I				
space is needed, use rev		be very specific in y	our answers. It additional				
3. TYPE OF MEDICATION							
Actifed							
4. REASON FOR USAGE							
Allergies							
·······		······································					
5. HOW LONG HAVE YOU T	AKEN THIS MEDICATION?						
13 days							
			i				
6. HAVE YOU TAKEN ANY (THER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSIC	CAL? (List two and reason for	(Mage)				
No		eria. (Elst type and reason to	wage /				
	•						
7. SIGNATURE OF APPLICAN			8. DATE SIGNED				
Selecca DD Form 2383, MAY 85	I White		5 May 87				

	DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATION	N
	Privacy Act Statement	
AUTHORITY:	Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.	
PRINCIPAL PURPOSE:	To update a medical file as part of the application process to a U.S. Officer Training Corps (ROTC) Scholarship Programs, or the Uniform Health Sciences (USUHS).	
ROUTINE USE:	To determine medical acceptability for one or more of the service as Information will be released to authorized personnel involved in t Social Security number (SSN) is used for positive identification.	
DISCLOSURE:	Voluntary; however, failure to furnish the requested information process and hamper your candidacy.	will impede the selection
1. NAME OF APPLICANT (Las	t, First, Middle Initial)	2. SSN OF APPLICANT
	INSTRUCTIONS	
Please answer the f	following questions regarding use of medication. Be very specific in y verse side.	our answers. If additional
3. TYPE OF MEDICATION		
		·
4. REASON FOR USAGE		

- HOW I SHE HAVE YOU		
5. HOW LONG HAVE YOU	TAKEN THIS MEDICATION?	
		·
E HAVE VOIL TAVEN ANY	OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL? (List type and reason for	· w see 1
6. HAVE TOU TAKEN ANT	UINER MEDICATION IN THE EAST TO DATE FRIENDS TO THE SECRETARY	usage /
7. SIGNATURE OF APPLICA	NT	8. DATE SIGNED
		1

DD Form 2383, MAY 85

DD FORM 2489, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST

Privacy Act Statement

AUTHORITY:

Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE:

To update a medical file as part of the application process to a US Service Academy,

Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services

University of Health Sciences (USUHS).

ROUTINE USES:

To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection

process. The social security number (SSN) is used for positive identification.

DISCLOSURE:

Voluntary; however, failure to furnish the requested information will impede the

selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)

MOORE, JOHN X.

2. SSN OF APPLICANT 000-00-0100

INSTRUCTIONS TO EXAMINERS

Please read reverse side of this form before administering this test.

Indicate by letters in each given block which colors were observed by the examinee for each run of the test (e.g., R/W, G/R, etc.).

	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
1st RUN	G/R	w/w	G/W	G/R	R/G	W/R	W/W	G/W	R/R	3
2nd RUN	G/R	W/G	G/W	G/G	R/G	W/R	W/W	R/W	R/R	Ø
3rd RUN	G/R	W/R	G/W	G/G	R/G	W/R	w/w	R/W	R/R	Ø

3. REMARKS (Continue on reverse if necessary)

4. SIGNATURE OF EXAMINER		5. DATE SIGNED
D. Chee	ober - USOF	16 Jun 87

FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

PREPARATION FOR TESTING

- 1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.
- 2. Only one person should be tested at a time. (Others shall not be allowed to watch.)
- 3. Station examinee eight feet from lantern.
- 4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, <u>must be removed</u> prior to testing.

ADMINISTRATION AND SCORING

- 1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance.' Two lights are presented at a time in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors red, green, and white and top first."
- 2. Turn knob at top of lantern to change lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.
- 3. Expose the lights in random order starting with a RG or GR combination (Numbers 1 or 5), continuing until each of the nine combinations has been exposed.
- 4. If no errors are made on this first run of nine pairs of lights, examinee is passed.

- 5. If any errors are made on this first run, give <u>two</u> more complete runs.
- 6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.
- 7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.
- 8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors red, green, and white."
- 9. If an examinee takes a long time to respond, you should say, "As soon as you see the lights, call them"

REMARKS (Continued)

DD Form 2489, FEB 87

AFR160-13/AR40-29/NAVMEDCOMINST6120.2A/CGCOMDTINSTM6120.8B Attachment 18 20 October 1989

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST											
				Priva	cy Act Sta	tement					
AUTHOR	<u>TY</u> :	Title 1	Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).								
PRINCIPA	L PURPOS	Reser	To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).								
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	· · · · · · · · · · · · · · · · · · ·			INSTRUC	TIONS TO	EXAMINE	RS	<u>.</u>			
Indica					_		d by the ex	xaminee fo	r each ru	n of the test	
	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN	
1st RUN											
2nd RUN											
3rd RUN											
3. REMARKS (c											
4. SIGNATURE OF EXAMINER 5. DATE SIGNED											

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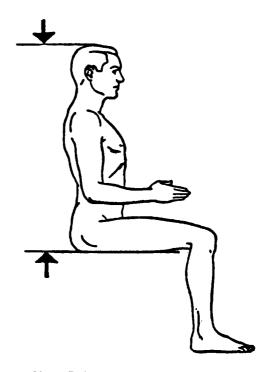
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REMARKS (Continued)

ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS

This attachment gives guidelines on the additional medical information needed along with the physical examination of applicants to a US service academy (Air Force, Military, Naval, Coast Guard, Merchant Marine), Four-Year ROTC Scholarship, or the USUHS.

- a. Reading Aloud Test (RAT). Administer the RAT to all applicants. The test must be given as follows:
- (1) Have the examinee stand erect, face the examiner across the room, and read aloud the statement in 2 below, as if he or she were confronting a class of students.
- (2) If he or she pauses, even momentarily on any phrase or word, the examiner immediately and sharply says, "What's that?" and makes the examinee start over again with the first sentence of the text. The true stammerer usually will halt again at the same word or phonetic combination, and will often show serious stammering.
 - "You wish to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet, he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter, when the ooze of snow or ice is present, he slowly takes a short walk each day. We have often urged him to walk more and smoke less, but he always answers, "Banana oil!" Grandfather likes to be modern in his language."
- b. Sitting Height. To measure sitting height, have the examinee sit on a hard surface, hips flexed at 90 degrees (°), lower legs dangling free, and torso erect, with head facing directly forward. Measure from the top of the head to the top of the hard surface the examinee is seated upon. Measure sitting height to the nearest quarter of an inch. (See diagram.)



- c. Near Point of Accommodation. Have the examinee wear his or her usual corrective lenses. The object of the test is to determine the nearest point where the examinee can read print that is 1 millimeter (mm) (.62 Snellen-Metric), or J-2) high. Hold the test card so near the eye that the examinee cannot read it, then slowly move it away until the examinee can read the print correctly. Record the results for each eye in diopters. If an ophthalmologist or optometrist is doing the test, with the manifest refraction findings in place, use monocular push-up amplitude of accommodation and record the results for each eye in diopters.
- d. Near Point of Convergence (NPC). The object of the test is determining the point on a ruler where eye convergence is the greatest. Place the ruler's zero mark about 15 mm from the corneal surface. Start the movable object at the far end of the ruler, and move it slowly toward the nose. The point of convergence is the point on the ruler where eye convergence is the greatest, but without breaking fusion. Record the results in millimeters.
- e. Red Lens Test. The examinee should be 30 inches from a tangent screen or a central fixation point. The fixation point should be on a plain wall, 48 inches from the floor, with intersecting lines of 45°, 90°, 135°, and 180°,

running at least 20 inches from the point of fixation. These lines may be marked at 4-inch intervals, and a cord 30 inches long fastened at the fixation point to measure the testing distance, the examinee's eye should be on an exact line, perpendicular to the fixation point so that the head and eyes are not tilted in any direction. Seat the examinee on an adjustable stool and steady his or her head by placing the chin on a chin rest, so that the visual axis will not change during the test. Put a red lens in front of one of the examinee's eyes. Then move a point of light outward in the six cardinal directions from the center of the screen; right, left, up and to the right, up and to the left, down and to the right, and down and to the left. Instruct the examinee to follow the light with his or her eyes, without moving his or her head, and to tell you if there

is either a change in the color of the light (suppression) or a doubling of the light (diplopia). Demonstrate a change in the color of the light at the beginning of the test, showning that it may be either red, white, or pink, by using an occluder. Move the light into one of the upper diagonal fields until the brow cuts off the view from one, to verify that the examinee understands. The examinee should report a change in color. Place a five diopter prism, base up or base down, before one eye to produce diplopia, which the examinee should report. This will avoid the danger of routine negative responses. If you wish, alternate this prism with a plano lens of the same size to confuse the examinee. Note and record the point on the screen if the examinee has diplopia or suppression when no prism is being used.

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